NHS Improvement

Monitor: annual report and accounts 2015/16

Monitor

Annual report and accounts
1 April 2015 to 31 March 2016

Presented to Parliament pursuant to Schedule 8, paragraph 21(3)(a) of the Health and Social Care Act 2012.

Ordered by the House of Commons to be printed 21 July 2016.

HC 401

Any enquiries related to this publication should be sent to us at: enquiries@improvement.nhs.uk

This publication is available at https://improvement.nhs.uk/resources/

Print ISBN 9781474129077
Web ISBN 9781474129084

ID 17021606 07/16

Printed on paper containing 75% recycled fibre content minimum

Printed in the UK by the Williams Lea Group on behalf of the Controller of Her Majesty's Stationery Office

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Publication code: Corp 02/16

About NHS Improvement

NHS Improvement is responsible for overseeing foundation trusts, NHS trusts and independent providers. We offer the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, we help the NHS to meet its short-term challenges and secure its future.

NHS Improvement is the operational name for the organisation that from 1 April 2016 brings together Monitor, NHS Trust Development Authority, Patient Safety including the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

About Monitor

As the sector regulator for health services in England, our job is to make the health sector work better for patients. As well as making sure that independent NHS foundation trusts are well led so that they can deliver quality care on a sustainable basis, we make sure: essential services are maintained if a provider gets into serious difficulties; the NHS payment system promotes quality and efficiency; and patients do not lose out through restrictions on their rights to make choices, through poor purchasing on their behalf, or through inappropriate anti-competitive behaviour by providers or commissioners.

This report covers the period from 1 April 2015 until 31 March 2016, before the establishment of NHS Improvement as the operational name for Monitor and the other transferring organisations. Monitor continues to exist as a legal entity, and throughout this report we have continued to refer to the organisation as Monitor.

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Performance report: overview

Monitor's role

Monitor's strategy 2014 to 2017: helping to redesign healthcare provision in England, published in 2014, had six elements:

1. Making sure public providers are well led – by setting a required standard that all NHS providers have to meet (our foundation trust authorisation standard or 'bar') and by seeking to control the risk that foundation trusts, once authorised, fall back below the required standard, taking remedial action if they do so. We also work with others to help develop foundation trust capabilities.

2. Making sure essential NHS services are maintained – if a provider, whether an NHS foundation trust or an independent sector provider, gets into such serious difficulty that it is unlikely to be able to continue providing its essential services for much longer.

3. Making sure the NHS payment system promotes quality and efficiency – for example, by working with NHS England to design and operate the payment system for all NHS services.

4. Making sure procurement, choice and competition operate in the best interests of patients – by helping commissioners and providers make sure patients do not lose out through poor commissioning, restrictions on their rights to make choices or inappropriate anti-competitive behaviour.

5. Promoting change through high quality analysis and debate, and by encouraging innovation – especially influencing people in frontline organisations, where the change required to improve patient care needs to happen.

6. Making sure Monitor is a high performing organisation – so that we could deliver our strategy after Monitor's responsibilities expanded significantly and our organisation grew correspondingly.

In addition, *Monitor's business plan for 2015/16* described how we intended to achieve our strategic objectives during the year, taking account of developments such as the Five Year Forward View. Our priorities were to:

- drive and support provider operational improvement – by helping foundation trusts become more efficient
- drive and support long-term sustainability – by helping to redesign care delivery
- operate effectively – for example, by bringing in more people with clinical and frontline operational experience.

Chairman's foreword

I am pleased to introduce Monitor's annual report and accounts for 2015/16, the first since I became Chairman of Monitor and Chairman Designate of NHS Improvement in August 2015. During the year Monitor continued with its important existing activities and prepared for the creation on 1 April 2016 of NHS Improvement. NHS Improvement brings together Monitor, the NHS Trust Development Authority (TDA), Patient Safety including the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

Together we concentrate expertise on healthcare improvement, regulation and patient safety, with a mandate and the resources to work right across the NHS. While Monitor and TDA will remain as legal entities, we will have a single operating model for our people, our resources and our responsibilities to government and the NHS. I am grateful to the joint working group of senior leaders from all the bodies involved, who helped design the new organisation and are overseeing implementation of the integration programme while remaining very focused on our external obligations.

Our principal focus is to support and enable urgent operational improvement in NHS provider organisations and the long-term sustainability of the healthcare system; in addition, we are the health sector regulator. To do this we will build on the achievements of the previous successful organisations and functions, and add new capability as well as a greater sense of collaboration with system leaders. While recognising and celebrating our diversity, everyone shares a single set of values centred on providing the healthcare system with support, development and constructive challenge.

Our NHS faces the formidable task of providing care at the quality patients deserve and within the resource provided principally by the government. In striking that balance, our NHS clearly needs more support and access to improvement and innovation activities than at any point in recent history, which makes NHS Improvement's remit both exciting and challenging.

Regulation, inspection and improvement all have a role to play. The challenge is to establish the right balance between them, and we have made a shift in emphasis: first and foremost, we offer real support to providers and local health systems. We do, of course, hold boards to account, and sometimes it is still necessary to intervene. In the short term, the scale of many trusts' financial and operational challenges means more involvement than we intend long term. But our ambition is to support first, building deep and lasting relationships with trusts and working alongside them to help them to improve – only intervening when we have to. Our purpose is better health, transformed care delivery and sustainable finances: a purpose that we know NHS patients, carers, staff and organisations all share with us.

I am delighted that we appointed Jim Mackey as Chief Executive of Monitor and Chief Executive Designate of NHS Improvement. Jim, who joined in November 2015, has 25 years' experience in our NHS and an exceptional record in achieving change, particularly during 10 years at Northumbria Healthcare NHS Foundation Trust. He has influenced national policy on new and innovative models of emergency care, and is passionate about taking an integrated approach to improving services.

I am equally pleased to welcome our new non-executive directors to the board: Lord Carter, Lord Darzi, Professor Dame Glynis Breakwell, Laura Carstensen and Richard Douglas. They bring a wealth of expertise and knowledge to NHS Improvement, as do Sigurd Reinton, formerly a member of Monitor's board, and Caroline Thomson and Sarah Harkness, who join from TDA's board.

In conclusion, I would like to thank the members of Monitor's board who have stepped down for their contribution. My predecessor, Baroness Joan Hanham, chaired the organisation and guided it through some far-reaching changes. The hard work of Tim Heymann, Heather Lawrence, Iain Osborne and Keith Palmer led to a better NHS and a better experience for patients. And I am grateful to David Bennett, who stood down in October 2015 after five years as Monitor's Chief Executive. He made an invaluable contribution to our NHS.

I hope this report offers an insight into the commitment and professionalism of our staff. I know they will play a vital part in NHS Improvement's work in the year ahead.

Ed Smith CBE
Chairman of Monitor and Chairman of NHS Improvement
4 July 2016

Introduction from the Chief Executive

This has been one of the most challenging years in the NHS's history. The rising pressures, which we have seen trusts and their staff working hard to cope with in recent times, continued to increase as record numbers of people sought treatment. Alongside this, the financial picture turned ever more difficult.

Yet NHS staff have done a remarkable job keeping the service running: for example, over 112,000 more people were treated in emergency departments within four hours in January than the year before. I'd like to record my thanks to all in the service who do their utmost for patients every day. The NHS remains among the best healthcare systems in the world.

In this tough environment, Monitor's approach has been increasingly to support foundation trusts, not simply to act as a regulator. We were determined this year to set a challenging but achievable tariff to avoid making unrealistic demands. We worked closely with our partner organisation, the NHS Trust Development Authority (TDA), before and after the announcement of NHS Improvement's creation, in developing plans to help the sector tackle the twin challenges of demand and financial pressure. In particular, we have taken a joint approach to creating and developing measures to help control spiralling spending on agency staff.

I'm pleased to say that partnership working has extended well beyond the boundaries of TDA and Monitor, with both organisations working with NHS England and other partners to fulfil the long-term aims set out in the Five Year Forward View. We have seen a strong focus on future care models through our involvement with the vanguards programme, intensive support for the areas that need it most through the Success Regime and a new joint approach to planning that will see organisations in local areas – providers, commissioners and local authorities – working together to design services and care for their patients. Local and regional commitment to true partnership working is crucial, not only to improving care and patients' experience, but to ensuring we have strong, sustainable organisations fit to tackle the current challenges and respond to change in the future.

Leadership and frontline roles in the NHS are among the toughest jobs right now**.** We need to continue to focus on how we can develop NHS staff in these demanding roles and help them deal with the long-term challenges, including how every part of an organisation can help itself become more efficient, not least through implementing the Carter review's recommendations.

As NHS Improvement we will continue to offer practical help to providers and local health systems, building on the best that Monitor and TDA have achieved. A supportive approach – working with and for the service – will be fundamental to the new organisation as we seek to build long-term, sustainable improvement: support will come first and intervention will follow only when necessary.

I look forward to working with everyone at NHS Improvement, including the new executive team: every member brings a wealth of knowledge and experience to lead the new organisation. And I'd like to thank Monitor's staff for all their hard work in the past year, not least in helping to launch NHS Improvement successfully.

Jim Mackey
Chief Executive of Monitor and Chief Executive of NHS Improvement
4 July 2016

Performance report: analysis

Making sure public providers are well led

We make sure trusts are well led so that they can provide high quality care for patients. Working closely with the Care Quality Commission (CQC), we safeguard patients by regulating quality, aiming to prevent problems arising in the first place. We also work with other organisations that lead on operational performance targets such as accident and emergency (A&E) waiting times and sustainability risks at trusts.

Assessing NHS trusts for foundation trust status

Our provider appraisal team defines the standard that NHS trusts must meet to become foundation trusts, and assesses applicants against it. We revised our *Guide for applicants* in October 2015 to make it easier to use and reflect changes to our well-led framework, which aligned our view of what a well-led organisation looks like with CQC's and the NHS Trust Development Authority's (TDA).

We authorised four foundation trusts during 2015/16:

- Bradford District Care, which provides mental health, learning disability and community health services
- Oxford University Hospitals, one of the largest teaching trusts offering acute services
- Birmingham Community Healthcare, which provides services for adults, children, people with learning disabilities, rehabilitation and dental services
- Sussex Community, which provides medical, nursing and therapeutic care.

At 31 March 2016 there were 155 NHS foundation trusts in total, over 60% of all trusts. We authorised two more – Mersey Care and Wirral Community – from 1 May 2016.

> Over 60% of all trusts are foundation trusts

Reviewing our assessment processes

We tightened our internal processes for granting foundation trust status, given the increased financial risk the NHS faces. This followed an independent review of the authorisation of St George's University Hospitals NHS Foundation Trust. The trust's finances deteriorated suddenly soon after it became a foundation trust in February 2015.

The review found no evidence that our appraisal process had broken down but identified areas we could improve. We accepted its recommendations in full. These included:

- strengthening our approach to financial governance by scrutinising the scope of financial reporting procedures and working capital reviews to ensure they remain fit for purpose in the current financial climate
- working with reporting accountants to understand the breadth and depth of the work required on these reviews
- obtaining updated third-party assurances where an authorisation is delayed for one month or more since previous confirmations.

We will continue to monitor our processes and change them if necessary to make sure they are fit for purpose.

Table 1: Assessments summary 2009 to 2016

Year	2009/ 10	2010/ 11	2011/ 12	2012/ 13	2013/ 14	2014/ 15	2015/ 16
Referred	7	11	5	12	5	6	3[1]
Reactivated	-	-	-	-	1	8	4[2]
Assessed	20	14	10	10	15	8	12[3]
Authorised	14	7	7	2	2	6	4
Deferred	1	1	1	5	3	1	2[4]
Paused (pending CQC outcome)	-	-	-	-	6	1	1[5]
Postponed	4	6	1	3	2	-	5[6]
Withdrawn	1	0	3	0	4	2	1[7]
Rejected	0	0	0	0	0	0	0
Total no. of foundation trusts	129	136	143	145	147	151	155

[1] Lincolnshire Community Health Services, Sussex Community, Mersey Care.
[2] Oxford University Hospitals, Norfolk Community Health and Care, Birmingham Community Healthcare, Wirral Community.
[3] This figure represents all in-year movements and does not include trusts whose applications were postponed and reactivated in the same year. Trusts with multiple interactions in 2015/16 were: Norfolk Community Health and Care – postponed, reactivated and then postponed a second time; Birmingham Community Healthcare – postponed, reactivated and authorised; Wirral Community – postponed and reactivated.
[4] Royal Liverpool and Broadgreen University Hospitals, Dudley and Walsall Mental Health Partnership.
[5] South West London and St George's Mental Health.
[6] Surrey and Sussex Healthcare, Norfolk Community Health and Care (twice), Lincolnshire Community Health Services, Wirral Community.
[7] Coventry and Warwickshire Partnership.

Table 2: Monitor's applications pipeline 2015/16

	In progress	Deferred/ postponed	Paused pending CQC outcome	Total Monitor pipeline
Pipeline at 31 March 2015	7	3	3	13
Referred from TDA	3			3
Reactivated	4	(3)	(1)	-
Authorised	(4)			(4)
Deferred	(2)	2		-
Postponed	(5)	5		-
Paused	(1)		1	-
Withdrawn		(1)		(1)
Pipeline at 31 March 2016	2	6	3	11

Significant transactions

Our provider appraisal team evaluates major transactions that foundation trusts may propose, such as mergers and acquisitions. Our review can help trusts decide whether a particular transaction makes sense in terms of care quality, finance, operational issues and – where relevant – choice and competition. We aim to identify risks early and tailor a streamlined work programme proportionate to the risks in each case. We try to maximise the chances of success and minimise disruption to trusts, balancing potential risks against the need to support rapid change.

We assessed several significant transactions during the year:

- Chelsea and Westminster Hospital NHS Foundation Trust's acquisition of West Middlesex University NHS Trust
- South Devon Healthcare NHS Foundation Trust's acquisition of Torbay and Southern Devon Health and Care NHS Trust
- Royal Free London NHS Foundation Trust's significant capital investment
- Cornwall Partnership NHS Foundation Trust's acquisition of community healthcare services from Peninsula Health.

Regulating providers

Our provider regulation team monitors foundation trusts' performance and takes remedial action where this falls below the required standard. We identify problems early and act quickly to minimise the impact on patients. Our principal tool for doing this is the NHS provider licence, which includes requirements on pricing, choice and competition, integrated care and continuity of services, as well as conditions relating to governance. All foundation trusts and non-exempt independent providers of NHS services must meet these licence conditions.

Responding to challenges at foundation trusts

Today's combination of changing and growing healthcare needs, an expanding population and constrained public funds means trusts are facing significant operational and financial challenges. Many struggled to meet key national standards during the year, including waiting-time targets for A&E, routine operations and some cancer treatments. They also struggled to deal with increased demand for diagnostic tests, partly due to staff shortages and ineffectively organised services. In particular, delayed transfers of care (where medically fit patients cannot leave hospital because the care they need is not yet in place) hampered performance, while spending on agency staff severely damaged trusts' financial position.

> We identify problems early and act quickly to minimise the impact on patients

To help trusts meet these challenges we adapted our approach to regulation by introducing with TDA measures to reduce spending on agency staff and management consultants.

In the past 12 months we found 16 additional foundation trusts in breach of their licence and took formal action (see Table 3 below); four foundation trusts demonstrated sufficient improvements for us to remove all the formal action to which they had been subject (see Table 4 below).

Table 3: NHS foundation trusts found in breach of their licence during 2015/16

Trust	Breach	Action taken
Lancashire Teaching Hospitals NHS Foundation Trust	Finance and governance	We made a legally binding agreement with this trust to effectively implement a financial recovery and sustainability plan to improve its financial position.
King's College Hospital NHS Foundation Trust	Finance and governance	We made a legally binding agreement with this trust to effectively implement a financial recovery and sustainability plan to improve its financial position.
Norfolk and Norwich University Hospitals NHS Foundation Trust*	Finance and governance	We made a legally binding agreement with this trust to develop an A&E, cancer and referral-to-treatment (RTT) improvement plan. Additionally, we made an agreement for the trust to effectively implement a financial recovery and sustainability plan to improve its financial position.
St George's University Hospitals NHS Foundation Trust	Finance and governance	We made a legally binding agreement with this trust to effectively implement a financial recovery and sustainability plan to improve its financial position.
City Hospitals Sunderland NHS Foundation Trust	Finance and governance	We made a legally binding agreement with this trust to effectively implement a financial recovery and sustainability plan to improve its financial position.

Trust	Breach	Action taken
Warrington and Halton Hospitals NHS Foundation Trust	Finance and governance	We made a legally binding agreement with this trust to effectively implement a financial recovery and sustainability plan to improve its financial position.
Great Western Hospitals NHS Foundation Trust	Finance	We made a legally binding agreement with this trust to effectively implement a financial recovery and sustainability plan to improve its financial position and to address weaknesses in its financial governance.
Wirral University Teaching Hospital NHS Foundation Trust	Finance and governance	We made a legally binding agreement with this trust to effectively implement a financial recovery and sustainability plan to improve its financial position.
Cambridge University Hospitals NHS Foundation Trust	Finance and governance	After a CQC inspection identified care quality issues, we placed this trust in special measures. We made a legally binding agreement with the trust to: • develop and effectively deliver an action plan to address the issues identified by CQC • effectively implement a financial recovery and sustainability plan to improve its financial position.
Taunton and Somerset NHS Foundation Trust	Finance and governance	We made a legally binding agreement with this trust to effectively implement a financial recovery and sustainability plan to improve its financial position.
South East Coast Ambulance Service NHS Foundation Trust	Governance	We made a legally binding agreement with this trust to commission a forensic review, a governance review and a patient impact review following changes made to the standard operating procedures for emergency 111 calls.
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	Governance	We made a legally binding agreement with this trust to work with an improvement director, develop an RTT recovery plan and a governance action plan.
Liverpool Women's NHS Foundation Trust	Finance	We made a legally binding agreement with this trust to effectively implement a financial recovery and sustainability plan to improve its financial position.
North Essex Partnership University NHS Foundation Trust	Governance	We made a legally binding agreement with this trust to develop a governance plan following an external governance review and to improve quality of care following the CQC inspection report

Trust	Breach	Action taken
		and warning notices.
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	Finance and governance	We made a legally binding agreement with this trust to effectively implement a financial recovery and sustainability plan to improve its financial position and address weaknesses in its financial governance.
Derbyshire Healthcare NHS Foundation Trust	Governance	We made a legally binding agreement with this trust to develop a governance action plan to address the findings of the employment tribunal investigation, the Deloitte 'well-led' review and the CQC inspection report.
Southend University Hospital NHS Foundation Trust**	Finance	We made a legally binding agreement with this trust to effectively implement a financial recovery and sustainability plan to improve its financial position.

* Norfolk and Norwich University Hospitals NHS Foundation Trust was found in breach of its licence on governance grounds in April 2015 and subsequently found in breach of its licence on financial grounds in February 2016.
** Southend University Hospital NHS Foundation Trust was found in breach of its licence on governance grounds in November 2011 and subsequently found in breach of its licence on financial grounds in March 2016.
Note: this table does not include all foundation trusts in breach of their licence – only those found in breach during 2015/16. At the start of 2015/16, 29 foundation trusts were in breach of their licence.

Table 4: NHS foundation trusts ceasing to be subject to formal regulatory action in the year to 31 March 2016

Trust	Breach	Date action lifted
Bolton NHS Foundation Trust	Finance	August 2015
Cumbria Partnership NHS Foundation Trust	Governance	December 2015
Calderstones Partnership NHS Foundation Trust	Governance	February 2016
The Dudley Group NHS Foundation Trust	Finance	February 2016

Table 5: NHS foundation trusts currently under investigation (at 31 March 2016)

Trust	Reason for investigation
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust	Deterioration in the forecast financial position.
Great Western Hospitals NHS Foundation Trust*	Governance concerns triggered by multiple breaches of the A&E target.
Gloucestershire Hospitals NHS Foundation Trust	Governance concerns triggered by multiple breaches of the A&E target.
Mid Cheshire Hospitals NHS Foundation Trust	Financial sustainability concerns triggered by deterioration in the trust's financial position.
County Durham and Darlington NHS Foundation Trust	Governance and financial sustainability concerns triggered by deterioration in the trust's financial position.
Black Country Partnership NHS Foundation Trust**	Financial sustainability concerns triggered by a continuity of service risk rating of 2.

* Trust already in breach on financial grounds and subject to a further investigation for governance concerns.
** Investigation at the trust was closed on 4 April 2016 with no further action.

Special measures

> We continue to focus on ensuring trusts maintain and improve quality

Where we identify serious failures in the quality of care and are concerned that a foundation trust's management cannot make the necessary improvements without support, we will place a foundation trust in special measures. This is a set of specific interventions designed to improve care quality and leadership within 12 months, and is usually based on a recommendation from CQC's Chief Inspector of Hospitals. Such interventions typically include assigning a 'buddy' organisation and an improvement director to the trust.

Ten foundation trusts were in special measures at 31 March 2016 or had been during last year, while four exited (see Table 6 below).

Burton Hospitals NHS Foundation Trust, Tameside Hospital NHS Foundation Trust, The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust and University Hospitals of Morecambe Bay NHS Foundation Trust were removed from special measures after the Chief Inspector of Hospitals found significant improvements at the trusts.

During the year we continued to work with CQC and TDA to make the special measures regime more effective. In particular we focused on the most challenged

and longer-term special measures trusts, publishing an addendum to the special measures guidance setting out how Monitor, TDA and CQC will work together to help these trusts. Against the backdrop of a challenging financial environment in the health service, we continue to focus on ensuring trusts maintain and improve quality. We will continue to develop our approach to special measures and work with partners to ensure appropriate high quality support is in place.

In Table 6 below the foundation trusts highlighted in blue have exited special measures.

Table 6: Foundation trusts in special measures in the year to 31 March 2016

Trust	Date entering special measures	Reason for entering special measures	Date of leaving special measures	Reason for remaining in or leaving special measures
Burton Hospitals NHS Foundation Trust	July 2013	Keogh review: concerns about skill mix, junior doctor support and board information.	October 2015	Recommendation by Chief Inspector of Hospitals after the CQC inspection report published in October 2015. The trust made improvements in safety and leadership.
Medway NHS Foundation Trust	July 2013	Keogh review: concerns about clinical supervision and urgent care.	N/A	Recommendation by Chief Inspector of Hospitals to remain in special measures after the CQC inspection report published in January 2016. Following a review in April 2016, CQC found the trust had made significant improvements to secure quality care in key areas.
Sherwood Forest Hospitals NHS Foundation Trust	July 2013	Keogh review: concerns about a large backlog of complaints and appointments.	N/A	Recommendation by Chief Inspector of Hospitals to remain in special measures after the CQC inspection report published in October 2015.
Tameside Hospital NHS Foundation Trust	July 2013	Keogh review: concerns about infection control and out-of-hours cover.	September 2015	Recommendation by Chief Inspector of Hospitals after the CQC inspection report published in September 2015. The trust made improvements in critical care services, governance and dealing with complaints.
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	October 2013	CQC inspection, which raised concerns about staffing levels and dementia care.	June 2015	Recommendation by Chief Inspector of Hospitals after the CQC inspection in July 2015. The trust made improvements in quality and safety of patient care.
Colchester Hospital	November	Concerns about management of the cancer	N/A	Recommendation by Chief Inspector of

Trust	Date entering special measures	Reason for entering special measures	Date of leaving special measures	Reason for remaining in or leaving special measures
University NHS Foundation Trust	2013	care pathway.		Hospitals to remain in special measures after the CQC inspection report published in January 2016.
University Hospitals of Morecambe Bay NHS Foundation Trust	July 2014	Concerns about the safety of services (in particular, medical and nursing staff levels and a lack of clarity about the trust's future strategy).	December 2015	Recommendation by Chief Inspector of Hospitals after the CQC inspection report published in December 2015. The trust made improvements in all areas identified in the CQC inspection report published in July 2014.
East Kent Hospitals University NHS Foundation Trust	August 2014	CQC inspection identified problems with patient care, hospital governance and clinical leadership. Monitor has taken additional enforcement action following a breach of the four-hour A&E target.	N/A	Recommendation by Chief Inspector of Hospitals to remain in special measures after the CQC inspection report published in November 2015. Significant progress has been made (including an improved rating from 'inadequate' to 'requires improvement') following the appointment of new executive team members, but further improvement in quality and safety is still required. New concerns around end-of-life care were identified.
Norfolk and Suffolk NHS Foundation Trust	February 2015	CQC inspection raised concerns about safety of services, staffing levels and leadership at the trust.	N/A	Yet to be reinspected by CQC.
Cambridge University Hospitals NHS Foundation Trust	November 2015	CQC inspection raised concerns about safety, quality governance and disconnected governance arrangements. Monitor has taken additional enforcement action following deterioration in finances.	N/A	The latest CQC report for the trust, Addenbrooke's and the Rosie Hospitals in May 2016 noted improvements in all areas and was rated as 'requires improvement'.

Sector performance

We closely track foundation trusts' performance to help them address operational issues and ensure the best possible patient care. Throughout the year we analyse performance at individual foundation trusts and across the sector to better understand where operational and financial pressures exist and how to help the sector address them.

Foundation trusts faced unprecedented demand for services in 2015/16; many have struggled to meet key operational performance standards.

Accident and emergency

The urgent care system was under particular pressure, resulting in most foundation trusts' A&E departments missing the four-hour waiting-time target. The sector achieved an annual performance of 92.26% – significantly below the target of 95% and the previous year's performance of 93.45%.

> Foundation trusts faced unprecedented demand for services in 2015/16

With TDA, NHS England and the Department of Health (DH) we set up the Emergency Care Improvement Programme. The programme offered practical hands-on support to improve performance in 28 of the most challenged urgent and emergency care systems. The team comprised improvement experts, clinicians, analysts and communications experts.

Referral to treatment

Following Sir Bruce Keogh's review of waiting-time standards, the admitted and non-admitted referral to treatment (RTT) standards were abolished in June 2015. The RTT incomplete standard then became the sole measure of elective care waiting-time performance. This standard measures waiting-time performance for patients on incomplete pathways – that is, those still waiting to begin treatment.

The number of people waiting to begin elective treatment rose by about 17% (like for like) in 2015/16 to 2.1 million. This was driven by rising demand (referrals increased by about 5% in 2015/16) and insufficient planned capacity. Despite the significant increase in waiting lists, foundation trusts achieved the 92% standard for incomplete pathways with a performance of 92.4% in 2015/16.

We helped foundation trusts access additional capacity from the independent sector to improve performance. We also funded a programme which helped foundation trusts improve their data and reporting. For 2016/17, we will work with NHS England on programmes to ensure capacity matches demand and the total waiting list is shortened.

Cancer performance

Demand for cancer services rose in 2015/16, leading to a 6% increase in the number of patients beginning treatment compared to the previous year. Under increasing pressure, foundation trusts failed to achieve the 62-day urgent GP referral target in each quarter of 2015/16.

Long waits for diagnostics, especially endoscopy tests, lengthened overall cancer waiting times. With TDA and NHS England, we co-ordinated our approach to improving endoscopy waiting times by helping providers access additional endoscopy capacity in the independent sector.

Foundation trusts achieved the other seven cancer standards in 2015/16.

Infection control

In 2015/16 foundation trusts reported a decrease in the number of C. difficile cases associated with lapses in care (1,348 compared to 1,374). But the number of foundation trusts that breached their C. difficile targets at the end of 2015/16 increased from 13 to eight.

Financial performance

We compiled the consolidated accounts for the foundation trust sector, providing an audited public record of financial performance in the year. As in previous years, the accounts will be laid before Parliament before the summer recess. We also tracked the financial performance of foundation trusts on a monthly basis.

Our monthly monitoring information revealed another exceptionally challenging period for foundation trusts. For the third consecutive year, they reported an overall deficit before impairments and transfers. The size of the deficit was £1.10 billion (before impairments, transfers or charities), which was £170 million worse than planned. Over 65% of foundation trusts were in deficit at the end of the year; most were acute trusts.

The deterioration in financial performance was again largely driven by expenditure growth during the year exceeding revenue growth. The cost of unplanned agency staff contributed £917 million to the adverse variance despite the implementation of agency controls in the second half of the year. However, this was softened by non-agency employee expenses being £158 million below plan. A shortfall of £120 million in savings against planned cost improvement programmes also contributed to the adverse position.

The earnings before interest, tax, depreciation and amortisation (EBITDA) margin declined significantly in 2015/16. The overall margin at 2.3% was below the 3.9% achieved in 2014/15. This was also below the 5% threshold we use to assess foundation trusts' long-term financial sustainability. While the operating revenue

exceeded plan by £1.114 billion, continued cost pressures reduced the planned EBITDA by more than £234 million, or 18.0%.

As in previous years, foundation trusts significantly underspent capital expenditure (capex) against plan. In 2015/16 the gross capex was £3.676 billion, 27.8% below plan. By category the largest underspend was in property, land and buildings.

Diagnosing issues at foundation trusts more quickly

We continued to develop our capability and capacity to rapidly diagnose why a foundation trust might be in trouble. This helps us develop the right intervention to enable improvements as soon as possible. We:

- developed and introduced a diagnostic methodology and tools that systematically and comprehensively assess issues at foundation trusts and identify those requiring action
- created an investigations team to support our frontline regulation teams.

Both developments have already reduced the duration of our investigations, allowing us to take rapid actions at foundation trusts in difficulties. We will further aim to reduce the time to diagnose issues.

Developing interim leadership

During the year we saw an increase in the need for interim executive and turnaround support for foundation trusts in difficulty. We responded by continuing to develop our capacity to use senior expertise outside Monitor. For example, we worked with the Royal Colleges' Faculty of Medical Leadership and Management to identify strong medical leaders to provide executive support to foundation trusts facing significant quality issues.

Since the beginning of last year, the number of senior executives we can call on to support our work with foundation trusts has more than doubled and now includes a richer mix of potential interim executives with nursing, operational and medical backgrounds. We placed 35 candidates at 20 foundation trusts. Securing strong executive candidates with a financial background remains a challenge and we will continue our effort to develop this capacity as part of NHS Improvement.

Support for foundation trusts in special measures from high performing trusts

We worked with DH and other national partners to develop support for trusts in special measures that would enable them to exit within 12 months. We designed a peer improvement programme to provide these trusts with the best proven leadership, clinical and management capability available in the NHS. It offers:

- improvement advice from a partner trust

- improvement delivery, where a partner trust provides more intensive support
- peer operational control, where the partner trust becomes accountable for running the trust's operations.

> Patient care is protected at all times

Partnership working between Guy's and St Thomas' NHS Foundation Trust and Medway NHS Foundation Trust was an early example of support that is enabling Medway to improve quickly. This approach is being considered at Sherwood Forest NHS Foundation Trust. Although the programme is in its pilot stage, evidence from overseas and other sectors suggests this approach can be effective.

Support for financial improvement

In light of the severity of the NHS's financial challenge, we developed a financial improvement programme open to a selection of about 20 NHS trusts and foundation trusts on a voluntary basis early in 2016/17.

This programme builds on our extensive experience of working with many foundation trusts to improve their financial performance. It aims to provide expertise on the ground to help trusts implement financial improvements (including the identification of initiatives to save £50 million). It is structured to ensure patient care is protected at all times.

We expect this to reduce these trusts' deficits in 2016/17 and improve their cash positions. We also expect it to fund itself through the savings achieved.

Whistleblowing and complaints: encouraging an open and honest culture

Whistleblowing

Following the Freedom to Speak Up Review in February 2015, we worked hard to improve the experience of whistleblowers in the NHS. With TDA and NHS England we fulfilled one of the review's key recommendations – establishing a national whistleblowing policy for all NHS organisations. We also helped CQC set up the Office of the National Freedom to Speak Up Guardian. We continue to develop an employment support scheme to help whistleblowers return to work, which we hope to pilot in 2016/17.

We have further improved the experience of whistleblowers who contact us by strengthening our centralised team that deals with all whistleblowing concerns and establishing a process to handle concerns sensitively and robustly.

> We greatly value those working in the NHS raising concerns with us

We greatly value those working in the NHS raising concerns with us. This year we received 60 whistleblowing cases. We analysed all of these and determined whether they were relevant to our role and, if so, what we needed to do to pursue the matter. In some cases this involved – in a manner agreed with the whistleblower – contacting the relevant foundation trust for further information. In others, whistleblowing information directly contributed to a decision to open a formal regulatory investigation. Unless concerns were raised with us anonymously, we explained the overall outcome to the whistleblower.

Complaints

This financial year, we received 656 complaints about health services, 495 of which were about foundation trusts. Wherever relevant we share complaints with CQC and TDA to inform their picture of individual trusts. Our memorandum of understanding with Healthwatch England describes how we share intelligence at a national level and regionally with local Healthwatch organisations. Where we receive complaints that give us concern about a foundation trust's governance or quality governance, we consider whether we need more information from the trust and then decide whether to take formal regulatory action.

Supporting foundation trusts

Developing our Provider Sustainability Directorate

The Provider Sustainability Directorate was established during 2015/16 to give improvement and development support to foundation trusts and their local care economy partners, complementing our regulatory levers. The directorate works with national and local partners to make sure effective support is available as providers tackle clinical, financial and operational challenges.

In its first year of operation the directorate has combined focused service improvement with culture and leadership development support, including:

Operational improvement: Working with 10 to 15 trusts at any one time, we provided diagnostics, onsite support, workshops and best practice visits to help achieve key NHS Constitution standards in cancer, urgent and emergency care, RTT and mental health.

Culture programme: This two-year programme offers resources for providers to work on culture using the principles of collective leadership, and is led by the directorate's development team in partnership with the King's Fund. It began in autumn 2015, and three pilot foundation trusts are taking part: Central Manchester University Hospital, Northumbria Healthcare and East London. Together we are developing practical tools to help providers design and implement their leadership

strategies, enabling them to create cultures conducive to high quality, compassionate care.

Local care economy sustainability: Since September 2015, we have provided analytical and advisory support to Cambridge and Peterborough, one of the most challenged local care economies. We strengthened levels of trust to enable all local providers to co-operate on an ambitious transformation programme, where relationships between national and local stakeholders are paramount to success.

Workforce efficiency: In response to trusts' growing problems controlling their expenditure on agency staff, the workforce efficiency team provided intensive support to 10 trusts and lighter-touch support to more than 50 others to determine their current agency spend and explore areas for improvement.

> We are … enabling them to create cultures conducive to high quality, compassionate care

The directorate will be developing and expanding both our longer-term capability building and shorter-term operational support to providers and their partners, to empower leaders and develop improvement capabilities.

Making sure essential NHS services are maintained

If a trust gets into serious difficulty that threatens its ability to provide essential services, we must intervene to make sure those services remain available for the people who need them. Our responsibility also extends to independent sector providers that need to hold a licence from us.

Helping the most troubled trusts and local care economies

During 2015/16, there was a noticeable increase in the number of trusts with severe problems. Working with national partners we took action where finances deteriorated, governance issues arose or operational performance was poor.

We increasingly find that problems at foundation trusts cannot be resolved by or in the trust alone, but require a long-term response across the local care economy or the reconfiguration of services:

- our transformation and turnaround team worked intensively with foundation trusts to diagnose their issues and to develop and implement solutions
- our contingency planning teams (CPTs) worked with local commissioners to redesign services in local health systems where foundation trusts are not sustainable in their current form.

Cambridge and Peterborough local care economy

We are working with national partners to oversee the system transformation programme run by Cambridge and Peterborough Clinical Commissioning Group (CCG). The programme aims to secure sustainable services and ensure medium-term financial sustainability. This work will have an impact on three foundation trusts:

- Peterborough and Stamford Hospitals NHS Foundation Trust
- Cambridge University Hospitals NHS Foundation Trust
- Cambridgeshire and Peterborough NHS Foundation Trust.

We expect the programme to conclude during 2016.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

We published our CPT's report in August 2015, which concluded that the trust is unsustainable in its current form and that it needed operational improvements, demand management initiatives and transformed services to become sustainable.

Since then, Monitor has worked with the trust, its commissioners and other local stakeholders to make short-term improvements and ensure that local services are transformed for longer-term sustainability. The local strategic plan will be incorporated into the Norfolk and Waveney system transformation plan in summer 2016.

Tameside Hospital NHS Foundation Trust

We published our CPT's report in September 2015, concluding that the trust was clinically and financially unsustainable in its current form. Our CPT recommended establishing an integrated care model (ICO) for Tameside's population. A programme board comprising local stakeholders has been established under our oversight, to lead implementation of our CPT's recommendations.

The ICO was established in shadow form in April 2016 after local community services transferred to the trust. The programme board is working towards fully implementing the ICO in April 2017.

Medway NHS Foundation Trust

In spring 2015, we arranged further close working between Guy's and St Thomas' NHS Foundation Trust and Medway under an 'enhanced buddying' arrangement. The aim was to support Medway's leadership team to improve care quality and exit special measures.

Following a review in April 2016, CQC found the trust had made significant improvements to secure quality care in key areas. CQC is due to reinspect the trust in autumn 2016 when we expect it will have made sufficient progress to exit special measures.

King's College Hospital NHS Foundation Trust

> We worked with stakeholders and external advisors to strengthen leadership, stabilise the operational and financial position, and address the underlying deficit

Since January 2015, we have helped King's College Hospital NHS Foundation Trust find a sustainable solution to its significant operational and financial issues.

We worked with stakeholders and external advisors to strengthen leadership, stabilise the operational and financial position, and address the underlying deficit.

We continue to help the trust to transform its services and to develop a longer-term strategic plan with its system partners to secure its sustainability, which will form part of the local system transformation plan submission in summer 2016.

St George's University Hospitals NHS Foundation Trust

Since May 2015, we have helped St George's University Hospitals NHS Foundation Trust to solve its significant operational and financial issues.

We strengthened the trust's leadership by appointing an interim chair in March 2016 for six months with an option to extend the appointment to 18 months. We are helping the trust develop a transformation plan for 2016/17 to improve its financial

performance. We continue to work with the trust's local system partners and our national partners to improve its operational performance and care quality.

Cambridge University Hospitals NHS Foundation Trust

Cambridge University Hospitals NHS Foundation Trust was placed in special measures in September 2015 after a CQC inspection found staff shortages that affected the safety of patient care, and led to capacity issues, significant numbers of cancelled operations and backlogs of appointments. Governance and performance management were not always effective. We took further enforcement action when the trust's finances deteriorated.

We are working with the trust's local system partners and our national partners on a quality improvement programme. We have strengthened the trust's leadership by appointing a chief executive and an experienced board advisor. The trust is implementing a financial recovery plan which achieved considerable cost improvements during 2015/16.

Sherwood Forest Hospitals NHS Foundation Trust

After an inspection in June 2015, CQC found the trust had not made sufficient progress to exit special measures. Since then, we have worked with DH and our national partners to identify and approve a long-term partner to help the trust improve care quality: Nottingham University Hospitals NHS Trust was chosen.

Since February 2016, Nottingham University Hospitals NHS Trust has deployed staff at Sherwood Forest to address CQC's concerns and help improve quality. We are working with both trusts on their longer-term plan to merge into one organisation.

Regulating independent providers of NHS services

Since 1 April 2014, all independent providers of NHS services have had to hold a provider licence unless exempt under DH regulations. The licence allows us to help commissioners to protect essential local services if an independent provider fails.

At 31 March 2016, 105 independent providers held licences.

With NHS England we continued to ensure commissioners consider which of their services would be at risk if a provider failed, and therefore should be designated as commissioner requested services (CRS). At 31 March 2016 there were 14 independent providers of CRS in our risk assessment and financial oversight regime.

In August 2015, we opened the first investigation at an independent provider, after concerns about the financial viability of Peninsula Community Health Community Interest Company. Our investigation focused on ensuring continuity of services throughout the process to find a new provider for adult community services in Cornwall and the Isles of Scilly. We closed our investigation after these services were eventually transferred to Cornwall Partnership NHS Foundation Trust on 1 April 2016.

Making sure the NHS payment system promotes quality and efficiency

We are jointly responsible with NHS England for the NHS payments system. We lead on developing the methodology for price setting, enforcing the pricing regime, approving local modifications to national prices and developing the proposed rules for local pricing. NHS England specifies how services are defined for payment purposes. We work together on agreeing the national tariff.

National tariff 2016/17

We are responsible for publishing the national tariff, which sets out what trusts are paid for the services they provide. The tariff's 'efficiency factor' is our expectation of the extent to which trusts can deliver the same services, to the same level of quality (or better), at a lower cost than previous years. Over the past five years we have set it at about 4%. Our aim for 2016/17 was to set savings targets that were challenging but achievable: given trusts' difficult financial and operational circumstances during the last year, we wanted to avoid making unrealistic demands of organisations already under pressure. Although major opportunities for greater NHS efficiency still exist, our priority in setting the tariff for 2016/17 was to help trusts break even and return to financial stability while managing increasing demand and making ambitious longer-term plans for improving patient care.

> "Our aim for 2016/17 was to set savings targets that were challenging but achievable"

The efficiency factor for 2016/17 is therefore 2%. We also set an inflation uplift of 3.1% to recognise rises in trusts' costs – for example, due to changes in pension arrangements and National Insurance contributions. In addition, we took account of an anticipated increase of 17% in contributions to the Clinical Negligence Scheme for Trusts. In response to trusts' feedback we delayed until 2017/18 making more far-reaching changes to the tariff system, such as top-up payments for specialised services or moving to a different 'currency' for payments for admitted patient care.

We received over 350 responses to our statutory consultation on the tariff proposals. Only 2% of commissioners and 6% of trusts and other providers raised objections, so the tariff came into effect on 1 April 2016 with only minor adjustments.

Locally determined prices

Local modifications to prices are intended to ensure healthcare services are provided where they are needed, even if the cost is higher than the national price. During 2015/16 for the first time we used our statutory powers to protect services for patients by changing the national prices that local commissioners pay a trust.

University Hospitals of Morecambe Bay NHS Foundation Trust successfully applied to us for a local modification to the national tariff to protect services in six specialties, including A&E, surgery and paediatrics. Our decision acknowledged the trust's increased costs in running services across multiple sites in rural locations, while noting that commissioners and providers still needed to do more to solve local financial problems.

Helping local care economies adopt payment approaches for new care models

The Five Year Forward View's proposed new models for providing care will break down barriers between GPs and hospitals, between physical and mental health, and between health and social care. The efficiency of these models will be crucial in closing the NHS's funding gap: they will therefore have to be underpinned by new approaches to payment, which will be pivotal in encouraging local care economies to adopt the new models.

To help this process, we developed several 'local payment examples' that suggest how new payment approaches might work. These take account of the experiences of local care economies in England and abroad, and cover:

- achieving integrated care
- developing urgent and emergency care networks
- improving mental healthcare to establish parity of esteem.

> "The efficiency of these models will be crucial in closing the NHS's funding gap"

We will refine our payment examples as we learn more from local care economies that implement the new models, and will then publish new payment approaches that could be mandatory or used voluntarily.

Costing transformation programme

The costing transformation programme aims to improve the quality of costing information in the NHS. Costing healthcare more accurately will improve patient outcomes by identifying where and how resources are used and exposing inefficiencies. The programme supports the use of patient-level costing systems – computerised information systems in hospitals that track and analyse the costs of care incurred by individual patients.

Since launching the costing transformation programme in March 2015, we have drafted new healthcare costing standards for England with help from six acute trusts. We intend these standards to bring consistency to costing NHS services as well as improving reporting and accuracy. The six trusts are now testing how effective and

easy to implement the standards are before we develop a version that can be used across the acute sector.

We also propose to move to a single annual cost collection covering all provider activities. All providers would then have to follow the new costing standards when reporting costs. Information from this collection would be far more detailed than that currently held.

Making sure procurement, choice and competition operate in the best interests of patients

We ensure that procurement, patient choice and competition operate in patients' best interests. Our strategic priorities in 2015/16 were helping patients, providers and the service understand how choice and competition affect them and benefit patients, and focusing action where it would most benefit patients.

How choice and competition are working

We continued to offer advice and support to commissioners and providers to help develop new care models and resolve local issues within the framework of the rules relating to commissioning, choice and competition. Over three-quarters (77%) of those who requested support found it useful.

Part of our advisory role is to ensure planned mergers that work well for patients can proceed smoothly and effectively. During the year we advised a range of organisations considering mergers, alongside our statutory role advising the Competition and Markets Authority on the patient benefits of proposed mergers.

We investigate whether aspects of the service are working well for patients. With NHS England we measured the extent to which patients are being offered a choice about where they receive care. We surveyed more than 2,700 patients whose GPs had referred them for an outpatient appointment in the previous 12 months. Of these, 40% said they had been offered a choice of hospital or clinic for their first outpatient appointment – a small improvement on 38% the year before, but the number aware of their right to choose decreased from 51% to 47%. We are continuing to help the service use these findings to increase the number of patients exercising their right to choose. For example, we are working with several clinical commissioning groups (CCGs) to support and enable patient choice locally and with NHS England to develop a choice improvement guide for CCGs.

> "Those aware of their right to choose decreased from 51% to 47%"

In another study we reviewed how GP services are working for patients, focusing on the role of choice and commissioning. The research covered 3,200 patients and included interviews with 25 GP providers as well as information from NHS England, the Care Quality Commission and others. We found that resource constraints had restricted providers' ability to respond to patients' needs, and few had opportunities to set up new services or expand existing ones. We suggested that commissioners could help by being more transparent and flexible, especially when GPs want to establish new care models. We shared our findings with organisations such as NHS England, and integrated them into our own work – for example, when advising providers and commissioners on the procurement, choice and competition rules.

Following our research on how choice is working for patients in adult hearing services, published in March 2015, we developed resources for commissioners thinking about using choice in audiology services. These set out the key principles of well-implemented choice in such services and aimed to support decision-making.

Focusing investigations to benefit patients

We concluded our investigation into Northern, Eastern and Western Devon Clinical Commissioning Group (CCG). Northern Devon Healthcare NHS Trust had complained about the CCG naming Royal Devon and Exeter NHS Foundation Trust as its preferred provider of community services for adults with complex needs in east Devon, claiming the CCG's process for awarding the contract had been inadequate and unfair. We found the CCG had not breached the regulations but needed to do more to ensure value for money before awarding the contract. Although its approach would not work in all cases, it showed commissioners can be flexible in their processes for selecting providers.

> Commissioners can be flexible in their processes for selecting providers

We opened an investigation in July 2015 after a complaint from Care UK about the commissioning of elective care services at the North East London Treatment Centre by Barking and Dagenham CCG, Havering CCG, Redbridge CCG and Waltham Forest CCG. The issues relate to the CCGs' process to select Barking, Havering and Redbridge University Hospitals NHS Trust as a provider of elective care services at the treatment centre, and the proposed pricing arrangements. We are examining whether the CCGs' actions were consistent with the procurement, choice and competition rules and the National Tariff Payment System.

Promoting change through high quality analysis and debate, and by encouraging innovation

We collaborate with other national bodies to help those who run the NHS locally improve patient services, and we research ways of improving care. Supporting redesign of the NHS is central to our work.

Using research and analysis to help local decision-makers

During the autumn we published findings from three research projects designed to help NHS organisations' strategic decision-making in the face of rising demand and constrained budgets.

Understanding urgent and emergency care performance

> We suggested that trusts could concentrate on smoothing the flow of patients through inpatient wards to the point of discharge and beyond

We investigated the reasons why trusts found it so hard to meet the four-hour emergency care standard in the winter of 2014/15. We found this was because hospitals were too full – which most clinicians knew already, but our analysis demonstrated that A&E departments themselves had coped well with a 6% average rise in attendances. The bottleneck occurred in finding beds for patients admitted from A&E. Inpatient wards lacked capacity, which had a significant impact on the exit flow from A&E departments. We suggested that trusts could concentrate on smoothing the flow of patients through inpatient wards to the point of discharge and beyond, using measures such as schemes to provide care closer to patients' homes, more standardised management of non-complex elective patients, and smaller-scale but continuous operational improvements in general.

Delivering care closer to home

We developed materials to help local health system leaders decide whether to invest in schemes that deliver healthcare closer to patients' homes, what types of schemes to invest in and how best to implement them. While evidence indicates such schemes can improve patient outcomes and experiences, their impact on costs has been unclear. Our materials included calculations of the potential effects of the four most established types of community-based scheme on costs in a typical local care economy over five years. We found that such schemes could best be used to create capacity for managing increased demand for acute care over the longer term. They may not achieve immediate cost savings but can reduce the rate of spending growth by substituting for – or at least delaying – the need to invest in new hospital capacity. We identified the main challenges to designing and running effective schemes and some solutions, complementing our findings with case studies and an online platform for trusts to share insights.

Improving productivity in elective care

In research developed with the Royal College of Ophthalmologists and the British Orthopaedic Association, we examined the efficiency and productivity of elective services in ophthalmology and orthopaedics at a range of NHS providers and five international centres. We identified techniques that clinicians and managers can work on together for boosting productivity, such as simplifying pathways for lower-risk patients and enabling lower-grade staff to undertake routine tasks usually done by consultants.

> We identified techniques that clinicians and managers can work on together for boosting productivity

These measures benefited patients: for example, by improving clinical outcomes and shortening hospital stays. We found trusts' performance varied widely at every stage of the ophthalmology and orthopaedics pathways – specifically in staff costs, overhead costs and number of appointments – implying potential savings of 13% to 20%. The techniques can be applied to other elective care pathways for similar productivity gains, and we are now extending the research to more specialties.

Contributing to the Carter review

We contributed to Lord Carter's review of acute hospitals' operational productivity and performance, which found £5 billion of potential savings. We seconded four staff to the review team. Since publication of Lord Carter's final report in February 2016, we have helped lead implementation of the recommendations nationally and locally.

Implementing the Five Year Forward View

Success Regime

Problems in some local care economies are deep-rooted, long-standing and spread across the whole system rather than individual organisations: trusts alone cannot solve them. With our national partners we announced in the Five Year Forward View that we would develop an approach to tackling these issues across local systems, which previous interventions had not done. In June 2015 we launched the Success Regime with TDA and NHS England.

The Success Regime's aim is to challenge and support some of the most challenged care economies to improve the quality and sustainability of their services. It will address:

- short-term improvement against agreed quality, performance or financial measures
- medium and longer-term change, applying new care models if appropriate

- developing leaders across the local system and encouraging them to work together.

> Our role, with our partners, is to work with care economies to diagnose the underlying issues, develop solutions and ensure they are implemented

Our role, with our partners, is to work with care economies to diagnose the underlying issues, develop solutions and ensure they are implemented. The first three local care economies to enter the Success Regime are Essex; Northern, Eastern and Western Devon; and West, North and East Cumbria. After completing the diagnostic phase, they began developing the clinical models that will form part of the solution for each area. Emerging findings have been shared with the public, ministers and MPs, and public consultation will start in the summer.

Moving to place-based planning

In the NHS shared planning guidance, published in December 2015, we and our national partners set out a new approach to planning health and care services by place rather than around individual institutions, and over five years rather than a single year. We encouraged frontline leaders to agree locally appropriate boundaries, and by March they had formed 44 'footprint' areas. Each area developed a sustainability and transformation plan showing how it intends to pursue the Five Year Forward View's aims of improved health and wellbeing, transformed quality of care delivery and sustainable finances.

Devolution and place-based regulation

We worked with our national partners to support devolved areas, particularly Greater Manchester, which took control of its £6 billion health and social care budget in April 2016. Through our work on devolution, on sustainability and transformation plans and new care models, we supported and encouraged providers to collaborate with local partners to improve the quality and sustainability of services for patients. We published draft guidance setting out what represents good governance for trusts and foundation trusts operating in the context of a local care economy.

Supporting the vanguards

With TDA and NHS England we continued to develop new models to better integrate care and act as blueprints for future NHS services. Together we recruited eight urgent and emergency care 'vanguards', which will improve the co-ordination of urgent and emergency care services and reduce pressure on A&E departments. We also chose 13 hospital vanguards from 65 bids to explore collaboration in acute services, and are leading their development.

A total of 50 vanguards are now developing new care models. With our partners we engaged extensively with them, holding site visits, workshops and discussions. Based on their feedback, we and our national partners launched an updated support

package for the vanguards in December 2015. We also examined how our regulatory regime applies to new care models and how we may need to change it, working with several vanguards to understand the issues our regime raises and test new approaches. We co-chair the New Care Models Board, and have supported and advised new care models on payment, choice, competition and procurement issues, and major transactions.

System leadership and co-ordination

We continued to contribute to the collective leadership of the NHS and the Five Year Forward View's cross-system governance arrangements to enable national bodies to collaborate more effectively on key issues affecting the NHS.

We provided advice and guidance to the three taskforce reports on cancer, mental health and maternity care.

Designing the way forward for providers

We set out our vision for trusts and the support we will offer them as NHS Improvement in *Implementing the Forward View: supporting providers to deliver*, the first of a series of publications that will help turn the Five Year Forward View into reality, which we published in February 2016.

Making sure Monitor is a high performing organisation

To achieve the best for patients we strive to be a high performing and effective organisation, both in our day-to-day business and in preparing for the launch of NHS Improvement.

Patient and clinical engagement

In 2015 we strengthened our Patient and Clinical Engagement Directorate by recruiting our Nursing Director, Ruth May, and Deputy Medical Director Stanley Silverman. We recruited four part-time associate nursing directors, three part-time associate medical directors and two clinical fellows to ensure the directorate has input from clinicians and patients through outreach and other engagement programmes. This helps us make sure our decisions are in patients' best interests. The directorate provides in-house advice and helps other teams access external clinical expertise.

> The directorate has input from clinicians and patients through outreach and other engagement programmes. This helps us make sure our decisions are in patients' best interests

In 2015/16 we were heavily involved in designing, implementing and monitoring nursing agency and locum doctor pay caps, working with other Monitor directorates and our national partners. We also continued to support challenged trusts. This included bespoke support for more than 10 providers, some in special measures. We continued to support nursing and medical directors with educational events run jointly with TDA. Our directorate also played a leading role in the safer staffing project, which will support clinicians and managers to deliver safe and efficient care with a number of publications during 2016.

Beyond this, we worked closely with other Monitor directorates – for example, advising the provider appraisal team on authorisations and transactions. We also worked with colleagues in the Care Quality Commission to ensure that our regulatory actions align.

We continued to strengthen links with the wider clinical community, including national professional bodies, engaging it earlier and more readily. The Clinical Advisory Forum, comprising foundation trust medical directors and chief nurses, works closely with the directorate and acts as an external sounding board for the clinical advice we provide internally. We also fostered closer working relationships with our counterparts at TDA before the launch of NHS Improvement, aiming to avoid duplication and increase collaboration.

Equality and diversity

> We aim to recruit, develop and retain the most talented people, regardless of their background

We recognise that individuals and their different cultures, perspectives and experiences add value to the way the organisation works. We aim to recruit, develop and retain the most talented people, regardless of their background, and help exploit their talents to the full. We use the Two Ticks scheme in our recruitment process. This means we interview all candidates with disabilities who meet the minimum requirement for the role and are committed to ensuring no member of staff is disadvantaged because of their disability. At the end of 2015/16, 23% of staff had declared their ethnicity as Black, Asian and minority ethnic, an increase of 1% on 2014/15. During the year, 17 managers attended training on inclusive leadership, adding to the 98 employees who attended the previous year.

Recruitment

An increase in staff numbers over the last five years reflected the work of establishing the regulatory framework required by statute and supporting the growing number of challenged foundation trusts and local care economies. Our recruitment efforts aimed particularly to strengthen our provider sustainability capability. We recognised our organisational need for staff with clinical and NHS operational backgrounds. At the end of 2015/16 we had 15 roles filled by people with a clinical background, while 132 employees (23%) had previous professional experience of the healthcare sector, of whom 68% had direct experience of working in the NHS.

Recruitment overall was severely reduced ahead of the establishment of NHS Improvement on 1 April 2016. This served to mitigate the impact on existing employees of a proposed organisational structure that reflected the government's requirement for arm's length bodies in the health sector to reduce costs.

Monitor staff in post

Table 7: Monitor staff in post 2011-16

	March 2011	March 2012	March 2013	March 2014	March 2015	March 2016
Staff in post	148	181	299	424	464	569

Table 8: Monitor staff profile by year

	Female (%)	Male (%)	Average age (years)	Staff turnover (%)	Black and minority ethnic (%)
2009/10	57	43	36	12.4	15
2010/11	61	39	36.6	11.3	16
2011/12	55	45	36.6	21	20.3
2012/13	56	44	36.2	12	18
2013/14	54	46	36.2	12.7	21.4
2014/15	52	48	36.3	17.1	22.4
2015/16	52	48	36.5	14.4	23.1

Monitor's employee engagement

We ran a full employee engagement survey in October 2015. It attracted a response rate of 82%, an 11% increase on the previous year's full survey. The top three results were: 'I care about the future of the work we do' (92%), 'I have the knowledge and skills I need to do my job' (88%) and 'My line manager treats me with respect' (88%). Areas that had significantly improved were: 'My team regularly looks for ways to make improvements' (a 31% increase on the previous year's survey), 'I have access to the training and development I need to do my job well' (improved by 18%) and 'I have the equipment and resources I need to do my work properly' (improved by 16%).

Complaints about Monitor

We are committed to being open and honest about mistakes we make, and learning from them. This year we received five complaints about Monitor. Two of these related to decisions not to take regulatory action against different foundation trusts, which we did not uphold. One complaint raised concerns about how we ran the contingency planning team process at a foundation trust. This identified learning for future work that we have started to apply elsewhere.

> We are committed to being open and honest about mistakes we make, and learning from them

One complaint was about how we handled a whistleblowing case in 2014/15, which we partly upheld on the basis that our communication with the whistleblower could have been better; we have already made changes to address this. We also partly upheld a complaint about delays in determining a complaint about the commissioning of prosthetics services. As a result we are setting up an internal process to ensure that competition case teams engage promptly with complaints to give early feedback to those involved. We are also considering how we can do more to explain our approach to a case and the expected timeframes involved.

Business plan for 2015/16

At the end of 2015/16, Monitor's business plan contained 113 actions, of which:

- 81 (72%) were delivered in full
- 18 (16%) are now scheduled for delivery during the first quarter of 2016/17
- four (4%) are expected to be delivered between the second quarter and the end of 2016/17
- 10 (9%) are either subject to significant delays or are not expected to be delivered.

The principal reason for delayed or incomplete actions is the impact of the transition to NHS Improvement – specifically, planned decisions to pause further work pending decisions on the operating model and organisational design. A small number of delays reflected the joint working arrangements with other public bodies on organisational priorities, such as the pricing system and the Peer Improvement Scheme. NHS Improvement's business plan actions will be tracked throughout the year and progress reported to the Board; in some cases, work from 2015/16 will continue into 2016/17. Overall, there was good progress against Monitor's three business priorities (see page 7), with most outstanding actions expected to be delivered early in the 2016/17 financial year.

Establishing NHS Improvement

Secretary of State for Health Jeremy Hunt announced the creation of NHS Improvement in a speech at the King's Fund on 16 July 2015. He described it as "an exciting opportunity for the people at Monitor and TDA to combine their respective skills to create a world-class capability to support NHS providers". NHS Improvement would be the operational name for the new organisation bringing together Monitor, TDA and the Patient Safety team from NHS England, making about 1,000 staff in all. In December 2015, the addition of the National Reporting and Learning System, run by Imperial College Healthcare NHS Trust, was announced. NHS Improvement was to be operational from 1 April 2016.

> The new organisation has been created to provide the system-level support that trusts will need to achieve the ambitions in *Implementing the Forward View*

Ed Smith, formerly Deputy Chairman of NHS England, was appointed Chairman-designate of NHS Improvement, taking over from Baroness Joan Hanham as Chairman of Monitor on 1 August 2015, and from Sir Peter Carr as Chairman of TDA on 1 December 2015. Lord Ara Darzi joined the board as Non-Executive Director.

On 5 October 2015, Jim Mackey, Chief Executive of Northumbria Healthcare NHS Foundation Trust, was appointed Chief Executive-designate of NHS Improvement on secondment from Northumbria Healthcare NHS Foundation Trust from 1 November 2015 to 31 October 2017, taking over from David Bennett, Chief Executive of Monitor, and from Bob Alexander, Chief Executive of TDA. For more details see the Remuneration report on page 81. He set out how NHS Improvement will approach its role in a plenary address at the King's Fund's annual conference.

In September 2015, the programme to design NHS Improvement was divided into eight workstreams:

- culture and values
- organisational design

- infrastructure
- legal and governance
- internal finance
- human resources
- external engagement
- new functions.

The integration steering group met for the first time in September 2015. John Wilderspin, formerly National Director for Health and Wellbeing Board Implementation at the Department of Health, was appointed Integration Director, and was assisted in developing the operating model and organisation design by KPMG. Roundtable discussions were held with trust and foundation trust chief executives to gather views on the vision, purpose and operating model for NHS Improvement.

Early in the new year, NHS Improvement began to work as one organisation, with fortnightly joint executive committee meetings and monthly joint board meetings. The executive structure for the new organisation was announced on 14 January 2016, and appointments made to the nine-strong executive team on 11 February. These appointments were made from senior staff at Monitor and TDA, and matched to those who could best fulfil the responsibilities required of the new organisational structure. Two executive regional managing director roles were advertised externally.

Announcement of the executive team coincided with NHS Improvement's first provider conference, held jointly with NHS Providers. Close to 600 leaders from NHS trusts and foundation trusts heard keynote speeches from Secretary of State for Health Jeremy Hunt, Jim Mackey, NHS England Chief Executive Simon Stevens, Ed Smith and Lord Darzi. NHS Improvement published *Implementing the Forward View: supporting providers to deliver*, describing the short and long-term challenges for providers, and how NHS Improvement intends to work with them in meeting those challenges.

> We will support first and intervene only when we have to

The new organisation has been created to provide the system-level support that trusts will need to achieve the ambitions in *Implementing the Forward View.* That document indicated that as we develop, we intend to open a new and critical dialogue with the service. In the short term, the NHS's financial and operational problems mean we will take a more involved and directive approach than in the longer term, when well-performing trusts will have considerable autonomy and our role will be one of oversight. We will support first and intervene only when we have to. We intend to work more effectively with our national system-level partners to

reduce the regulatory burden. We will also devise a single definition of success to be used by all national system leaders, and shift focus towards local health and care systems, not just individual organisations.

Staff across all organisations joining NHS Improvement were consulted and kept informed throughout the transition. A weekly update and documents answering staff questions were circulated; staff were surveyed on the vision and purpose for NHS Improvement, existing culture and ways of working. Jim Mackey and Ed Smith informed staff of major announcements before they were announced publicly. Those transferring from NHS England into TDA have also been consulted.

A summary of the integration programme's achievements was provided for NHS Improvement's Board meeting on 28 April 2016. The Board also received a paper proposing next steps. These included setting up an improvement programme to embed the work of the integration programme, and establishing the operating model and new directorate structures.

Sustainability report

Table 9: Monitor's greenhouse gas emissions

Greenhouse gas emissions			
		2015/16	2014/15
Non-financial indicators (tCO_2e)	Total emissions for Scope 2 (Energy Indirect) Emissions	N/A	N/A
	Total gross emissions for Scope 3 Official Business Travel Emissions	66*	45*
Related energy consumption (KWh)	Electricity: non-renewable	N/A	N/A
	Gas	N/A	N/A
	Expenditure on energy	N/A	N/A
Financial indicators (£000s)	Expenditure on official business travel	318	292

*This is the total of all measurable emissions for which data is available. Monitor staff may claim for taxis, or train journeys booked personally when travelling on business but identifying the emissions from these has not been possible due to data limitations.

Monitor occupies three floors of Wellington House; as this space is leased from the Department of Health (DH), the sustainability figures (including Scope 2, waste management and finite resource consumption) for the space will be reported in DH's annual report.

Financial commentary

Monitor's accounts have been prepared on a going concern basis. More detail can be found in Note 1 to the accounts. Monitor's net expenditure for the year was £66.4 million (2014/15: £72.3 million). The main categories of spend are:

Table 10: Main categories of spend

	2015/16 £m	2014/15 £m	Reference to accounts
Staff	49.2	39.5	Note 3
Contingency planning teams	1.0	8.6	Note 4
Trust special administration	-	7.4	Note 4
Other Professional services	3.8	7.1	Note 4
Property and office expenses	6.6	5.0	Note 4
Special measures reimbursements	2.1	2.1	Note 4
Depreciation and amortisation	2.5	1.4	Notes 4/7
Other	1.2	1.2	Note 4
Total	66.4	72.3	

The largest area of spend is staff costs, representing 74% of net expenditure in 2015/16 (2014/15: 55%). The increase in proportion of staff costs is due to the increase in staff overall compared to 2014/15 (571 average whole-time equivalents in 2015/16 compared with 466 in 2014/15) and spending less on externally commissioned projects: for example, there has been no new Trust Special Administration spend in 2015/16 and more work was done in-house, particularly contingency planning team activity.

Professional services spend relates to development and delivery of several Monitor functions; the largest single activity within the total relates to Monitor's programme of costing and coding assurance work, which cost £1.5 million in 2015/16.

Special measures reimbursements are costs of buddy agreements set up to support foundation trusts placed in special measures. Costs in 2015/16 were £2.1 million, which is consistent with the previous financial year.

In 2015/16 property and office expenses increased from £5.0 million to £6.6 million. This is mainly due to Monitor taking on additional space in Wellington House to accommodate extra staff. More detail on non-pay expenditure can be found in Note 4 to the accounts.

Grant-in-aid of £70.7 million was received during the year, of which £3.8 million was applied to the purchase of non-current assets. Net assets at 31 March 2016 were £6.8 million (31 March 2015: £2.5 million). The increase in net assets is primarily due to development of IT assets during the year combined with a reduction in the year-end payables due to the reduction in non-pay spend and more invoices being paid during the year.

Statement of payment practices

Unless the amounts charged are considered to be incorrect, Monitor has adhered to its policy to pay suppliers in accordance with the Better Payments Practice Code for the year ended 31 March 2016. Monitor aims to meet a 10-day payment target with outturn against this target as follows:

Table 11: Payment practices

	Number		Value	
	2015/16	2014/15	2015/16	2014/15
Total number of invoices	8,959	7,762	£30.0 million	£45.1 million
Invoices meeting target	8,112	7,251	£17.8 million	£26.5 million
Percentage meeting target	90%	93%	60%	60%

More detail of how money has been spent in 2015/16 can be found in the main accounts.

You can find a review of Monitor's activities and performance against business objectives during the year on pages 12 to 45. Our strategy for 2014 to 2017 set out our intentions to help the front line redesign how care is delivered.

For our performance against our business plan for 2015/16, see page 42. Our business plan focused on our role in helping the NHS address its two main priorities – short-term operational improvement and longer-term sustainability.

Disclosure to the Auditors

So far as the Accounting Officer and the Executive Directors are aware, there is no relevant audit information of which Monitor's auditors are unaware. The Accounting Officer and Board have taken all steps necessary to make themselves aware of any relevant audit information and to establish that Monitor's auditors are aware of this information.

Jim Mackey
Chief Executive
4 July 2016

Accountability report

Statement of Accounting Officer's responsibilities

Under the Health and Social Care Act 2012, the Secretary of State for Health has directed Monitor to prepare an annual report and accounts for each financial year in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Monitor and of its net expenditure, application of resources, changes in taxpayers' equity and cash flows for the financial year.

The Accounting Officer for the Department of Health has designated the Chief Executive, Jim Mackey, as Accounting Officer of Monitor. The responsibilities of an accounting officer, including responsibility for the propriety and regularity of the public finances for which the accounting officer is answerable, for keeping proper records and for safeguarding Monitor's assets, are set out in *Managing public money,* published by HM Treasury.

In preparing the accounts, the Accounting Officer has complied with the requirements of the government *Financial reporting manual* and in particular to:

- observe the accounts direction issued by the Secretary of State, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgments and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the government *Financial reporting manual* have been followed, and disclose and explain any material departures in Monitor's financial statements
- prepare the accounts on a going concern basis.

Governance statement 2015/16

Introduction

In managing the organisation's affairs, Monitor's Board is committed to achieving high standards of integrity, ethics and professionalism across all our areas of activity. As a fundamental part of this commitment, we support and adopt best practice standards of corporate governance within the statutory framework. This annual governance statement sets out how Monitor's resources have been managed and controlled in 2015/16 to enable this.

In July 2015, the Secretary of State announced the creation of NHS Improvement, which brings together Monitor, the NHS Trust Development Authority (TDA), the Patient Safety function from NHS England, the Advancing Change team from NHS Improving Quality, and the Intensive Support Teams from NHS Interim Management and Support (IMAS) to make a single integrated enterprise. NHS Improvement came into existence on 1 April 2016.

As this report covers the period from 1 April 2015 until 31 March 2016 (ie before the creation of NHS Improvement), and as it forms part of the annual report of Monitor, which continues to exist as a legal entity, Monitor is referred to throughout the report. However, it should be noted that since 1 April 2016 the boards of Monitor and TDA have identical membership, and meet jointly as one NHS Improvement Board. New Rules of Procedure have been developed which set out NHS Improvement's governance arrangements.

Monitor's governance framework

The Board

The Board's role is to lead the organisation by setting its strategy (including the organisation's vision, mission and values) and agreeing the framework within which operational decisions will be taken.

Board composition

The Heath and Social Care Act 2012 (the 2012 Act) stipulates that Monitor's Board is to consist of a chair and at least four non-executive directors appointed by the Secretary of State for Health. The chief executive and other executive directors who are Board members are appointed by the non-executive directors, subject to the Secretary of State for Health's consent. The number of executive directors on Monitor's Board must not exceed the number of non-executive directors.

Several changes have been made to Monitor's Board leading up to 1 April 2016 to reflect the creation of NHS Improvement. As there are no legislative changes to reflect the creation of NHS Improvement, Monitor's Board will continue to exist. From

1 April 2016, its membership has been identical to that of the TDA Board, and the two boards meet jointly to form the NHS Improvement Board.

Monitor's Board is now made up of eight non-executive directors and five executive directors. Ed Smith was appointed Chairman of Monitor and Chairman-designate of TDA on 1 August 2015 for a period of three years; he became Chairman of TDA on 1 December 2015. Baroness Joan Hanham (whose appointment as Chairman was extended by the Secretary of State in September 2014 until 31 March 2016) stepped down from her position through ill health in July 2015, and remained a non-executive director for the remainder of her term which ended on 31 March 2016. The remaining non-executive directors are Professor Dame Glynis Breakwell, Laura Carstensen, Lord Patrick Carter, Lord Ara Darzi, Richard Douglas, Sarah Harkness, Sigurd Reinton and Caroline Thomson.

Keith Palmer, the Deputy Chairman, stepped down from his position on 31 January 2016. Heather Lawrence, Iain Osborne and Tim Heymann stepped down from their positions on 31 March 2016.

David Bennett continued in his role as Chief Executive until 31 October 2015. Jim Mackey was appointed Chief Executive with effect from 1 November 2015. Stephen Hay and Adrian Masters continued in their executive roles as Managing Director of Provider Regulation and Managing Director of Sector Development respectively until 31 March 2016. From 1 April 2016, the executive directors on Monitor's Board are Jim Mackey (Chief Executive), Bob Alexander (Executive Director of Resources/ Deputy Chief Executive), Stephen Hay (Executive Director of Regulation/Deputy Chief Executive), Kathy McLean (Executive Medical Director) and Ruth May (Executive Director of Nursing).

No individual or group of individuals dominates the Board's decision-making. Collectively, the non-executive directors bring a valuable range of experience and expertise as they all currently occupy, or have occupied, senior positions in the healthcare sector, in the commercial sector and in public life. With the exception of those listed above, members of Monitor's executive team are not members of the Board but attended Board meetings on a regular basis and make presentations on pertinent matters arising from their respective directorates.

Non-executive directors

Monitor's non-executive directors are independent of management and have no cross directorships or significant links which could materially interfere with the exercise of their independent judgements. Arrangements for the handling of any possible conflicts of personal interest are set out in Monitor's Rules of Procedure.

Board members' terms and conditions of appointment are available on request from the Head of Governance.

Deputy chairman and senior independent director

Keith Palmer occupied the positions of Deputy Chairman and Senior Independent Director from 30 May 2014 until 31 January 2016. The principal responsibilities of Monitor's senior independent director are to:

- work closely with the chairman, act as a sounding board and provide support
- make themselves available for confidential discussions with other Board members who may have concerns they believe have not been properly considered by the Board as a whole
- act as a point of contact for stakeholders with concerns that have not been resolved through the normal channels, or for which such contact is inappropriate
- relay to the non-executive directors their observations and any views they may have received from stakeholders.

Chairman and chief executive

Baroness Joan Hanham was initially appointed as Monitor's Interim Chairman with effect from 20 January 2014 until 31 December 2014. In September 2014, the Secretary of State for Health decided to extend this appointment with effect from 1 January 2015 until 31 March 2016. Because of ill health Baroness Hanham stood down as Chairman in July 2015, and from 1 August 2015 Ed Smith was appointed Chairman of Monitor and from 1 December 2015, Chairman of TDA.

The chairman's role is to:

- provide effective leadership and management of Monitor's Board
- ensure that Monitor's Board, as a whole, plays a full and constructive part in developing and determining Monitor's strategy and overall objectives
- act as the guardian of Monitor's Board decision-making processes
- ensure that Monitor's Board has the information and advice needed to discharge its statutory duties
- ensure that Monitor, including the chief executive and other executive team members, communicate effectively with stakeholders, and that members of Monitor's Board develop an understanding of Monitor's major stakeholders.

Having acted on an interim basis for some time, David Bennett took on the substantive role of Chief Executive on 1 November 2012 and left Monitor on 31 October 2015. On 1 November 2015, Jim Mackey was appointed Chief Executive of Monitor. The chief executive's role is to:

- lead and manage Monitor as an organisation, including its staff and work programmes
- propose and develop Monitor's strategy and overall objectives, in close consultation with the chairman and the rest of Board
- be responsible, with the executive team, for implementing the decisions of the Board and its committees
- promote and conduct Monitor's affairs with the highest standards of integrity, probity and corporate governance
- lead the communications programme with stakeholders, jointly with the chairman.

How the Board operates

The 2012 Act established that the body corporate known as the Independent Regulator of NHS Foundation Trusts was to continue to exist and to be known as Monitor. The 2012 Act also established Monitor as the sector regulator for health, with a primary duty to protect and promote the interests of people who use healthcare services by promoting provision of healthcare services that:

- is economic, efficient and effective
- maintains or improves the quality of services.

In the exercise of powers under paragraph 10(1) of Schedule 8 to the 2012 Act, Monitor has made the Rules of Procedure to establish a Board and to regulate its procedures and those of its committees. The Rules of Procedure are published on Monitor's website. These have been updated to reflect the creation of NHS Improvement, and the updated version will be published on NHS Improvement's website.

To discharge its duties effectively, the Board must determine the scope of its activities and the areas of the organisation to which it will assign high priority. This 'job description' for the Board is set out in the Matters Reserved to the Board (Annex C to Monitor's Rules of Procedure), which reflect the Board's priorities and determine the extent of its intended direct involvement in particular areas of the organisation.

The Matters Reserved to the Board include the:

- establishment and maintenance of Monitor's strategic direction – reviewing, contributing to and approving Monitor's vision, mission and values

- approval of Monitor's corporate and business plans, including the distribution of Monitor's financial allocation as set out in the annual business plan and any subsequent material change to this
- approval of Monitor's risk management strategy/framework, including the determination of Monitor's risk appetite
- approval of all Monitor's significant regulatory policies before consultation with stakeholders and any material amendments following responses to consultation
- determination of any operational decision considered to be policy-determining (ie having strategic implications) and/or very high risk.

While the Matters Reserved to the Board reflect the Board's priorities and the matters in which it intends to be actively involved, they also delineate the areas in which the Board considers it appropriate to delegate authority to others, including Board committees, the chief executive and other executives. To ensure clear lines of accountability between the Board and the executive team, Monitor had a Scheme of Delegation (Annex D to the Rules of Procedure). The Scheme of Delegation reflected the job descriptions of Monitor's senior executives and follows from the Matters Reserved to the Board. The Scheme of Delegation is being revised to reflect the creation of NHS Improvement and will be published as part of the Rules of Procedure.

Monitor's Board has agreed a Code of Ethical Practice (Annex B to the Rules of Procedure), which provides a high level statement of the standards of practice expected of Monitor's Board members and its staff. The code explicitly reflects the 'Statement of Common Purpose' agreed in light of the findings of the Mid Staffordshire NHS Foundation Trust public inquiry, and recognises the importance of the principles and values identified in the NHS Constitution. Monitor is committed to taking account of these in all its decisions and actions.

Information required for the Board to operate

The Board has agreed a classification of the information it requires to carry out its duties. Having specifically considered the nature and quality of information required in each of these categories, the Board is content it receives information that ensures it is kept fully up to date on the issues arising which affect Monitor.

The Rules of Procedure govern the information to be submitted to formal Board meetings. In addition to these, executive committee members maintain regular contact with all the non-executive directors and hold informal meetings with them to discuss issues affecting Monitor.

In addition to internal advice, the Board may request independent and external professional advice on any matter relating to the discharge of its duties. The costs of

any such advice are met by Monitor, subject to the agreement between Monitor and the Department of Health (DH) as to funding for unforeseen circumstances that may arise during a financial year.

Head of governance

The head of governance is responsible for:

- advising the Board on all corporate governance matters
- ensuring that Board procedures are followed
- ensuring good information flow between the Board and its committees
- facilitating induction programmes for non-executive directors.

Any questions that stakeholders may have on corporate governance matters should be addressed to the head of governance at Monitor's office address.

Board effectiveness

Board meetings and attendance

The attendance of the Chairman, individual non-executive directors and executive Board members at Board and committee meetings during 2015/16 was as follows:

Table 12: Board meetings and attendance

Name	Board Max 11 meetings	Audit and Risk Committee Max 6 meetings	Nominations Committee**	Remuneration Committee Max 1 meeting	Technology Assurance Committee Max 5 meetings***
Joan Hanham*	1	N/A	-	-	N/A
Ed Smith*	8	1	-	1	N/A
Keith Palmer*	9	5	-	-	N/A
Sigurd Reinton	11	6	-	N/A	5
Iain Osborne	8	3	-	-	N/A
Heather Lawrence	11	N/A	-	1	N/A
Tim Heymann	8	N/A	-	N/A	N/A
Lord Ara Darzi*	3	N/A	-	N/A	N/A

Name	Board Max 11 meetings	Audit and Risk Committee Max 6 meetings	Nominations Committee**	Remuneration Committee Max 1 meeting	Technology Assurance Committee Max 5 meetings***
Lord Patrick Carter*	2	N/A	-	N/A	N/A
David Bennett*	6	3	-	-	N/A
Jim Mackey*	5	-	-	-	N/A
Stephen Hay	11	5	-	-	1
Adrian Masters	11	4	-	N/A	4

* These board members were not on the Board of Monitor for the whole of 2015/16. See section on board composition above.
** The Nominations Committee did not meet in 2015/16.
*** The Technology Assurance Committee has three independent members, all of whom attended all five meetings.

Induction

All non-executive directors who join the Board receive detailed induction information about Monitor, its structure, operations and corporate governance. Meetings are arranged with members of the executive team and other key senior staff members. Visits to NHS foundation trusts are also arranged.

Performance evaluation

The Board sets objectives for both the chairman and the chief executive. The chairman sets objectives for individual Board members. The chief executive sets objectives for the executive team against the objectives set for the Board and in relation to the delivery of the organisation's business plan.

Compliance with corporate governance codes of good practice

Monitor reviews its compliance against the *Code of good practice for corporate governance in central government departments*, the *UK corporate governance code* and the *NHS foundation trust code of governance*. Where they apply to Monitor, Monitor has complied with the main principles of each of these codes from 1 April 2015 to 31 March 2016, except for the following:

Table 13: Compliance with codes of good practice

Cabinet Office Code of Good Practice	NHS FT Code of Governance	UK Corporate Governance Code	Monitor position
N/A	**B.2.11** It is a requirement of the 2012 Act that the chairperson, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive, are responsible for deciding the appointment of executive directors.	**B.7.1** All directors of FTSE 350 companies should be subject to annual election by shareholders. **B.7.2** The Board should set out to shareholders in the papers accompanying a resolution to elect a non-executive director why they believe an individual should be elected.	Monitor's Executive Directors were appointed by the Board, rather than its Nomination Committee, as part of the determination of Monitor's organisation design and the appointments approved by the Secretary of State for Health.
N/A	**C.3.6** The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the organisation.	**C.3.6** The audit committee should have primary responsibility for making a recommendation on the appointment, reappointment and removal of the external auditor	Given the statutory composition of Monitor, the Comptroller and Auditor General, supported by the National Audit Office, acts as its external auditor.

Conflicts of interest

Monitor faces several potential conflicts of interest, including: (i) conflict of personal interest and (ii) conflict between bodies. Arrangements for handling any possible personal conflicts of interest are set out in Monitor's Rules of Procedure. We have agreed joint partnership arrangements with other healthcare regulatory bodies to manage any possible conflicts that might occur with them.

We are also required under Section 67 of the 2012 Act to be vigilant in exercising our functions for the possibility of either an actual or perceived functional conflict of interest, whereby one directorate might prefer or adopt a particular course of action

or decision that conflicts, actually or potentially, with the functions and decision-making of a different directorate. For this purpose, we distinguish between (i) 'functional conflicts', that is, those situations which by virtue of the 2012 Act constitute an actual or perceived conflict and so must be treated as such; for example, when exercising our competition and pricing functions, we must ignore our functions with regard to imposing additional licence conditions on NHS foundation trusts; and (ii) situations which are in reality not conflicts but operational manifestations of the overlap between different Monitor functions: these will be addressed and resolved by Monitor legitimately and reasonably balancing competing interests. Where we have resolved a conflict of interest, we must publish a statement setting out the nature of the conflict, the manner in which it was resolved and the reasons for deciding to resolve it in that manner. No such conflict was identified in 2015/16 and consequently, no statements were published.

Board committees

All committees' terms of reference are reviewed regularly during the year by the head of governance and by the Board as appropriate.

Audit and Risk Committee

Members: Keith Palmer (Chair), Sigurd Reinton, Iain Osborne.

At the committee's invitation, the Chief Executive (in his capacity as Monitor's accounting officer), Managing Director of Provider Regulation, Managing Director of Sector Development, Director of Strategy and Policy, Director of Financial Reporting and Risk Director, Head of Internal Finance, Head of Internal Audit (KPMG) and the external auditor (Comptroller and Auditor General; National Audit Office (NAO) on his behalf) attend meetings. The Head of Governance attends Audit and Risk Committee meetings and acts as secretary to the committee.

All non-executive directors have access to the minutes of all the committee's meetings. Following each Audit and Risk Committee meeting, the committee's chair presents a report to the Board.

Key duties of the committee include:

- appointing and managing the relationship with the internal auditors
- commissioning and receiving reports from the internal auditors on the adequacy of Monitor's internal control systems
- considering all relevant reports from the Comptroller and Auditor General, Monitor's external auditor, including reports on Monitor's accounts, achievement of value for money and the responses to any management letters issued by them

- in-depth review of Monitor's risk profile on report to the Board on managing and mitigating current and emerging risks.

The committee met six times in 2015/16. Key issues considered included:

- Evaluating the effectiveness of Monitor's risk management and internal controls on an ongoing basis. The committee receives risk reports at each meeting and, based on this information, evaluates risk management and instructs any improvements required. Using this information and that provided by Monitor's internal and external auditors, the committee has concluded that the control environment is adequate and effective.

- Internal audit, including reviewing Monitor's progress in implementing medium and high risk internal audit recommendations raised in 2014/15, setting priorities for the 2015/16 internal audit programme, and receiving reports from individual internal audit reviews throughout the year.

- Review of NAO's plans for auditing Monitor's financial statements and of the consolidated NHS foundation trust account. As NAO acts as Monitor's external auditors by statutory appointment, the committee has not formally reviewed NAO's effectiveness as its external auditor. NAO did not provide Monitor with any non-audit services in 2015/16.

Nominations Committee

Members: Heather Lawrence (Chair), Iain Osborne, David Bennett.

At the committee's invitation, the Executive Director of Organisational Transformation attends meetings. The Head of Governance attends Nominations Committee meetings and acts as secretary to the committee.

The Nominations Committee leads the process for Board appointments by evaluating the balance of skills, knowledge and experience among existing Board members and agreeing, for submission to ministers, a description of the role and capabilities required for particular appointments. The Nominations Committee also takes the lead on succession planning for the Board.

The Committee did not meet in 2015/16. In establishing the new Board for NHS Improvement, close interaction between the Chair and DH's Permanent Secretary was necessary, and a panel comprising these and an independent member was convened to oversee the selection process.

Remuneration Committee

Members: Iain Osborne (Chair), Keith Palmer, Heather Lawrence.

At the committee's invitation, the Chief Executive and the Executive Director of Organisation Transformation attend meetings. The Head of Governance attends Remuneration Committee meetings and acts as secretary to the committee.

Details of the Remuneration Committee and its policies can be found in the Remuneration report (see page 81).

The committee met twice in 2015/16. It considered Monitor's recognition framework, approval of senior appointments, remuneration for very senior managers (VSMs) and a number of policies relating to the transition to NHS Improvement.

In June 2015, the Secretary of State for Health wrote to all NHS bodies emphasising the importance of a review of the pay of the most senior staff in the NHS – chief executives and executive directors. Although these people do important jobs and deserve to be fairly rewarded, it is vital that we do not lose sight of the need to ensure that executive pay remains proportionate and justifiable. The same is true of those employed by Monitor. In light of this, the Remuneration Committee agreed that Monitor should be held to the same level of scrutiny regarding the payment of its senior executives as other NHS bodies. In 2015/16 the Remuneration Committee took responsibility for reviewing Monitor's policies on executive remuneration and considering whether the amounts paid are necessary and publicly justifiable.

Technology Assurance Committee

Members: Sigurd Reinton (Chair), Stuart Jobbins (Independent Member), Paul Willer (Independent Member), Ted Woodhouse (Independent Member).

The committee supports the Board by providing independent assurance on information strategy and associated project proposals. On the basis of the information provided to it, the committee provides assurance on key decisions or recommendations that have critical strategic significance or would materially affect risk.

Independent members of the committee have significant experience in senior leadership roles in large IT organisations and/or experience of leading large complex IT systems in multifunctional organisations. They use this experience to test and challenge Monitor's information and IT strategy and assure the Board that it is on track and meeting its objectives.

The committee met five times in 2015/16. Key issues considered included the increased demands on Monitor's information services department resulting from increased use of data analytics as well as increased monitoring of foundation trusts. The committee also considered technology issues arising from the transition to NHS Improvement, and increasingly takes a role advising the Board on how NHS Improvement can promote efficiency in the service through better use of technology.

Executive committees

The executive team is made up of the executive Board members and others who report directly to the Chief Executive, who is the Chair of the Executive Committee (ExCo). Alongside ExCo, other executive committees reflect Monitor's regulatory functions. Each was chaired by the Chief Executive for most of 2015/16, with membership consisting of relevant ExCo members. From 1 January 2016 to 31 March 2016, changes were made to the running of the executive committees to facilitate the transition to NHS Improvement. Members of the executive team took on responsibility for chairing executive committees so the Chief Executive could focus on priorities associated with establishing NHS Improvement. The frequency of executive team meetings increased to weekly, and members of TDA's executive team were invited to attend.

- The Operations Committee (OpsCo) was established in October 2015 to assist ExCo in ensuring that Monitor has appropriate and robust procedures and business processes in place and is operating effectively.

- The Controls Committee approves expenditure within the framework of delegated efficiency controls set out by the Department of Health. The committee also approves expenditure on external recruitment activities for Monitor's business as usual and its transition.

- The Foundation Trust Consultancy Approval Panel was set up in June 2015 to ensure that foundation trusts demonstrate the value for money of proposed consultancy support. It does this by approving consultancy expenditure over £50,000 proposed by any foundation trust receiving interim support from DH or in breach of its licence for financial reasons.

- The Provider Regulation Executive (PRE) focuses on operating a rigorous fit-for-purpose regulatory regime by monitoring the performance of all licensed providers of NHS-funded services on their obligations under the provider licence. It takes decisions on provider-related interventions and enforcement.

- The Provider Appraisal Executive (PAE) focuses on decisions relating to NHS trust applications to become foundation trusts. Should a decision on an application be considered to be policy-determining and/or high-risk, PAE will refer it to the Board. It also decides the risk ratings of significant transactions proposed by foundation trusts.

- The Pricing Executive focuses on developing and implementing a coherent, long-term pricing strategy to deliver appropriate benefits to patients, including production of the annual national tariff. Joint design with NHS England is managed through the Joint Pricing Executive, which has members from both organisations.

- The Co-operation and Competition Executive focuses on establishing and maintaining transparent, effective principles and procedures for managing competition complaints and investigating cases.
- The Provider Policy Executive was set up in October 2015 to ensure Monitor co-ordinates its approach to developing policy on authorising and regulating foundation trusts. This includes its approach to:
    - assessing NHS trusts for foundation status
    - supporting improvement of foundation trusts' operational performance and longer-term capability development
    - monitoring licensed providers' performance
    - interventions to prevent or manage service failure.

PRE and PAE therefore no longer consider provider policy issues, either for decision or information.

External directorships held by executive team members

Subject to certain conditions, and unless otherwise determined by the Board, executive team members are permitted to accept one appointment as a non-executive director. With effect from 1 May 2009 Stephen Hay was appointed non-executive director and Chair of the Audit and Risk Committee at the Department for Communities and Local Government, for which the remuneration is £10,000 a year. Kate Moore was Chair of Governors at a primary school until June 2015; the position was unpaid. Adrian Masters is the Treasurer of PACT (Prisoners' Advice and Care Trusts), a national charity that supports people affected by imprisonment; the position is unpaid.

Relationships with stakeholders

Stakeholder engagement

Monitor meets key stakeholders on a regular basis to discuss matters relating to foundation trust policy and broader questions on health reform.

During 2015/16, Board and executive meetings were held with organisations and individuals, including ministers, special advisers and senior officials from DH, TDA, NHS England, Care Quality Commission, NHS Providers, chairs, chief executives and finance directors of foundation trusts.

Events

We regularly run events and webinars to keep stakeholders informed and provide opportunities to discuss specific elements of the regulatory regime.

Monitor's website

Before the launch of NHS Improvement, our website, www.gov.uk/monitor, was the primary source of information on Monitor. It included our publications, information on foundation trust performance and on our corporate practices.

We have created a new website for NHS Improvement, which can be found at: https://improvement.nhs.uk/

Monitor's duties as a regulator

Duty to review regulatory burdens

Under the 2012 Act, Monitor is required to keep the exercise of its functions under review to ensure it does not maintain or impose regulatory burdens that it considers to be unnecessary.

Whenever we propose any changes to our regulatory framework, we consult on them so that those we regulate may comment on possible regulatory burden. In 2015/16, as a result of the financial pressures facing providers, we proposed and consulted on changes to our risk assessment framework to incorporate assessments of efficiency in our oversight of NHS foundation trusts' governance.

In 2015/16 we increased the frequency of trust financial reporting from quarterly to monthly to help us identify and address trusts' financial issues earlier. While this increased the reporting burden, we considered it a necessary response to the financial pressure the sector is under. In making this change, we sought to ensure the detail of the increased reporting was appropriate. This also enabled us to reduce the number of separate collections, which helps foundation trusts to manage their reporting to us.

In response to the financial issues facing the NHS in England, we introduced measures to limit the amount foundation trusts spend on agency workers (including doctors, nurses and clinical support) and consultants. As part of this, foundation trusts are required to adjust their operating models to work within the limits and report spending in these areas. We have sought to ensure that the incremental burden associated with these measures, while again considered necessary, is kept to an appropriate level.

We continued work with the sector begun in 2014/15 to consider the impact of our regulatory framework on innovation and new care models. As part of our ongoing work with the Forward View vanguards, we are considering how best to regulate these providers in an appropriate and proportionate manner.

Impact assessments

Under Section 69 of the 2012 Act, we must publish an impact assessment (or a statement explaining why an assessment is not necessary) when proposing

something likely to have a significant impact on those who provide healthcare services for the purposes of the NHS, those who use these services, or the general public, or would be likely to involve a major change to the activities of Monitor itself. In 2015/16, we undertook impact assessments under Section 69 of proposals:

- to impose caps on the prices paid by NHS providers for agency staff
- for the 2016/17 National Tariff Payment System.

We decided:

- to impose caps on the prices paid by NHS providers for agency staff as proposed
- to adopt the 2016/17 national tariff as proposed, with effect from 1 April 2016.

Following the impact assessment of the 2015/16 national tariff proposals, carried out in the previous financial year, we decided not to implement those proposals because objections from providers of NHS services exceeded the statutory thresholds provided for under the Act. The 2014/15 national tariff continued in effect for 2015/16, and most commissioners and providers adopted arrangements under that tariff for variations to prices, known as the Enhanced Tariff Option (ETO).

Macpherson recommendations on quality assurance of models

The Macpherson report, published in March 2013, made recommendations on the processes, culture and environment within which business-critical analytical models are quality assured. Government departments and arm's length bodies, such as Monitor, are required to implement the report's recommendations. In 2014/15 we identified four business-critical models, and this year we put in place a framework for identifying such models on an ongoing basis.

Under this framework, we identified four business-critical models in 2015/16. Three were business-critical last year; but the GP referral analysis model is a new business-critical model.

One model (the acute reconfiguration model), classed as business-critical last year, is no longer considered to be so for two reasons. Specifically, Monitor no longer faces a risk of judicial review since newer models developed by others, outside Monitor, are being used in 2015/16. Further, the model's anticipated wider use has not materialised. We will continue to keep this under review.

For information about the four business-critical models and our systems for quality assurance, see Table 14.

Table 14: Quality assurance processes

Description	Quality assurance processes in place
Long-term financial model (LTFM): used to understand the financial history, current position and financial forecasts of foundation trust applicants. It is also used to stress-test applicant trusts' forward assumptions to assess whether the applicants are financially viable. The model is business-critical because financial viability is a key criterion for foundation trust authorisation.	LTFM was developed internally by a modelling expert and has been externally audited by modelling experts on several occasions. All changes to the model go through a documented model update process, including segregation of duties and multiple-stage review processes. Large-scale changes to complex parts of the model are typically performed and/or reviewed by external modelling experts, although such changes are rare.
Monitor tariff calculation model: used to calculate the prices and related data points Monitor sets in the national tariff. The model is business-critical because its outputs are used in calculating what a provider of NHS services gets paid (by commissioners) for performing these services. It covers approximately £30 billion of NHS expenditure.	The model for the 2016/17 tariff was based on a 'rollover' model (ie on an existing set of prices with minor amendments). Given this, we quality assured the model in two stages: first, by applying an internal quality assurance process. Then we published the model as part of our s118 consultation, which allowed stakeholders to review it and feed back comments. We made minor amendments after this feedback.
Pricing impact assessment model: used to calculate the effect on income and expenditure for providers and commissioners of changes to national prices or pricing rules. The model is used to support Monitor's statutory duty to assess the impact of changes to the National Tariff Payment System. It is business-critical because its outputs are used in calculating what an NHS service provider is paid (by commissioners) for its services.	The model for the 2015/16 national tariff was developed by modelling experts at Monitor. The model was reviewed in two stages: independently, by an appropriately qualified third party; then stakeholders reviewed it as part of our s118 consultation, resulting in minor amendments.
GP referral analysis model: used to analyse whether a merger between providers of NHS elective care services is likely to cause competition concerns. It comprises a series of files containing software algorithms that manipulate Hospital Episode Statistics data. It is business-critical because it provides a foundation for Monitor's strategic advice and early input to trusts considering mergers, to ensure these are well planned and work well for patients.	The model was developed internally by modelling experts. All changes have been documented and a change process created. A version control system is in place for analytical auditing. The model will be subject to internal quality assurance in Q1 2016/17.

In line with the Macpherson recommendations, model owners in Monitor are accountable for implementing appropriate quality assurance procedures for their analytical models. In addition, we have worked to ensure we have an appropriate organisational framework for reviewing and reporting on these models. It was agreed in 2015/16 that a working group of suitably qualified staff would co-ordinate the Macpherson process within Monitor. This group advises on the quality assurance procedures for analytical models in line with the Macpherson recommendations and the identification of business-critical models. It can interact directly with model owners as required.

Further, the risk and performance team liaises with the group's chair as part of the quarterly reporting process to identify risk and assurance issues relating to the business-critical models. The risk and performance team, as part of its regular liaison with directorates, helps identify gaps and overlaps between the risks facing the organisation.

Harris recommendations on assurance regarding statutory arrangements

The Harris report, published in 2013, recommended that there should be greater assurance at board and departmental level that all statutory functions in the health and social care landscape established by the 2012 Act are being exercised appropriately. Monitor's Board is content that it understands the fundamental principle of public law that, where a function has been conferred by statute on a public authority, the public authority may not, unless expressly permitted to do so, further delegate the performance of that function to another body.

Internal control – statement from Jim Mackey, Monitor's Chief Executive

As accounting officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of Monitor's policies, aims and objectives. These are set out in the National Health Service Act 2006, the Health and Social Care Act 2012 and Monitor's corporate strategy and business plan. In doing so, I must safeguard the public funds and assets in accordance with the responsibilities assigned to me in *Managing public money* and the latest accounts direction from DH.

Purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives.

The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of Monitor's policies, aims and objectives
- evaluate the likelihood of those risks being realised and the impact should they be realised

- manage risks efficiently, effectively and economically.

The system of internal control has been in place in Monitor for the year ending 31 March 2016 and up to the date of approval of the annual report and accounts, and accords with HM Treasury guidance.

Risk and control framework

As Monitor experienced significant growth, development and change during 2015/16, its risk management framework, systems, processes and resources were subject to review and incremental change, where appropriate. We reviewed and updated our corporate risk profile from both a top-down and bottom-up perspective. Our network of risk champions continued to provide information on new and existing risks, share good practice and co-ordinate and support the embedding of an appropriate risk management culture in the organisation. Risk and performance registers and accompanying reports were regular agenda items at executive committee meetings and at OpsCo to ensure appropriate discussion of risks. This enabled formal escalation of risks for the attention of senior management for further review and challenge at the Audit and Risk Committee and the Board. As we transition to NHS Improvement, we continue to review and improve the efficiency and effectiveness of the organisation's risk management framework.

Principal risks facing Monitor during 2015/16

Monitor's annual plan identified that the organisation faced the following significant risks in 2015/16:

Table 15: Principal risks and mitigation

Risk	Mitigation – what did Monitor do to manage the risk?
Monitor fails to develop an effective strategy with our partners to address significant financial challenges in 2015/16	• Continued to work with our partners to share intelligence on the nature of the problem and to identify, develop and implement effective strategies to address significant financial challenges: specifically, agreeing stretch targets for foundation trusts and issuing guidance on cost controls relating to consultancy spend and the use of agency staff, as part of a package to help the NHS reduce spiralling agency staff bills.
Insufficient (Monitor) capability and capacity to handle the increasing number of foundation trusts in difficulty	• Created a Provider Sustainability Directorate that continues to grow. It will provide expert support for operational improvement at foundation trusts. • To ensure appropriate capacity and capability, our Provider Regulation Directorate conducted an organisational design project, which created 56 new roles. We introduced a new skill mix by recruiting more staff with NHS or turnaround or restructuring backgrounds.
Lack of capability and leadership in the NHS makes it more likely	• Established an Interim Leadership Solutions team and an interim contacts database.

Risk	Mitigation – what did Monitor do to manage the risk?
trusts will get into difficulty and be less able to recover	• Continue to provide good practice corporate governance training to foundation trust chief executives, chairs and senior executives. • Developed a wider leadership strategy and actively participate in the Leadership Academy programme focused on the chief executive's role. We surveyed chief operating officers to understand the type of development support we could provide. • Worked with NHS England, TDA, DH and the Healthcare Financial Management Association to develop a more strategically focused finance function across the NHS. We worked with TDA and NHS Providers to develop knowledge-sharing days on key topics and run events for medical, nursing and communications directors. • Continue to work on implementing the Smith review's recommendations and developing a national strategy with partner arm's length bodies.
Failure to turn around struggling foundation trusts at sufficient pace, leading to a lack of service continuity	• Subjecting the most distressed trusts to special measures and/or the failure regime. • A suite of regulatory tools, including powers to change board leadership, appoint improvement directors and buddy trusts, contingency planning teams and trust special administrators. • Developing a new model of management intervention, following the model of super-buddying established between Guy's and St Thomas' and Medway. • Developing a diagnostic toolkit to accelerate identification of causes of issues at trusts and solution design.
Planned NHS reform is not achieved if Monitor's contribution to Five Year Forward View (5YFV) fails to deliver anticipated benefits/is not sufficiently developed and implemented	• Considering where Monitor's business activities for 2015/16 are best aligned to support 5YFV. • Ensuring where relevant that work is co-ordinated across directorates with timely information sharing and progress updates. This includes an internal 5YFV co-ordination group. Named individuals are responsible for tracking progress across all 5YFV workstreams, and we have a co-ordinating group at operational level. • Regular updates to the Board and ExCo. • Across Monitor, we support implementation of 5YFV in four distinct areas: new care models, Success Regime, the overall NHS efficiency programme, leadership and improvement. (Directorate-level plans cover the risks associated with the delivery of these areas of work).
Challenges associated with Monitor's significant	• Ongoing reviews of management processes throughout 2015/16, and efforts to recruit a balance of leadership skills

Risk	Mitigation – what did Monitor do to manage the risk?
growth (early 2015/16); with developing and implementing joint working arrangements and establishing NHS Improvement at scale and pace (latter part of 2015/16)	and health sector experience. • Developing an outline programme plan for NHS Improvement integration; establishing a joint working group and developing detailed project plans for all programme workstreams. • Filling the integration programme team with staff from across Monitor, TDA and NHS England and securing external help to develop NHS Improvement's operating model and high level organisation design.
2016/17 national tariff is not accepted by the service and/or key stakeholders by 1 April 2016	To help shape the final 2016/17 national tariff proposals: • Carried out successful engagement on parts of the 2016/17 tariff proposals ahead of statutory consultation. • Invited the service to submit views on some of our proposals for the 2016/17 tariff (including currency design and relative prices, and national variations and locally determined prices). • Intending to publish our proposals for the efficiency factor, cost base and service development as soon after the spending review as feasible, so these can inform commissioners' and providers' planning.

Capacity to handle risk

Monitor's Board has responsibility for ensuring delivery of our strategies and goals as outlined in the 2015/16 annual plan. When setting these strategies and goals, the Board considers Monitor's specific statutory functions as outlined in legislation and Board members' wider understanding of the healthcare system (the latter being informed, among other things, by Board workshops).

When the strategies and goals have been established, detailed plans are drawn up for each strategy area with input from all staff. Risks against achievement of goals and strategies are reported to the Board on a quarterly basis. Monitor's internal audit strategy categorises our business into three systems (operational systems, support systems and the governance framework). Internal Audit considers the risks to Monitor in terms of these systems and this directs Internal Audit's priorities, which are reflected in the annual internal audit plan.

Monitor's Audit and Risk Committee considers risks faced by the organisation on a quarterly basis and reports its conclusions directly to the Monitor Board. Internal Audit makes its own regular reports to the Audit and Risk Committee based on its own work programme. The Board discusses the most significant risks and the actions identified to mitigate the likelihood and impact of those risks. On an annual basis, the Audit and Risk Committee evaluates the effectiveness of the risk

management framework and approves the annual internal audit plan for the following year.

Review of effectiveness

As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control. This review is informed by the work of the internal auditors and ExCo members who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports.

Monitor continues to enhance its internal controls environment above and beyond the minimum levels required. Monitor's management team continues to ensure that appropriate and relevant controls are embedded in all areas of Monitor's work.

Internal audit work covering compliance and intervention processes continues to provide me with adequate assurance that effective controls are either in place or being developed to a high degree of sophistication. Monitor's Board has maintained strategic oversight and review of internal control and risk management arrangements through regular reports by directors on their areas of responsibility and through specific papers for discussion at Audit and Risk Committee and Board meetings.

The Audit and Risk Committee, which meets on a quarterly basis, has considered:

- individual internal audit reports and management responses
- the internal auditor's annual report and opinion on the adequacy of our internal control system
- National Audit Office audit reports and recommendations
- regular reports on Monitor's corporate risk register, including the identification of risks to the organisation's system of internal control and information about the controls that have been put in place to mitigate these risks.

Any data losses experienced by the organisation would be reported to the Audit and Risk Committee. No such incidents occurred in 2015/16.

To my knowledge, and based on the advice I have received from those managers with designated responsibilities for managing risks and the risk management system, I am not aware of any significant internal control problems for 2015/16. As Monitor's accounting officer, I have gained assurance over the adequacy of Monitor's internal

control environment from individual assurances given to me by each member of ExCo as to the adequacy of the internal control environment within their own directorate.

Jim Mackey
Chief Executive
4 July 2016

Directors' report

The annual report and accounts have been reviewed in detail by Monitor's Executive Committee, Audit and Risk Committee and Board. At each point it has been confirmed that the annual report and accounts, taken as a whole, are considered to be fair, balanced and understandable. They provide the information necessary for Monitor's stakeholders to assess Monitor's business model, performance and strategy.

Our Board

Ed Smith CBE (Chair from 1 August 2015 and Chair designate of NHS Improvement)

Ed Smith is also the Lead Non-Executive Director for the Department for Transport, Pro-Chancellor and Chairman of Council at the University of Birmingham, a Member of the Competition and Markets Authority panel and a Member of Council and Treasurer of Chatham House.

He was the former Global Assurance Chief Operating Officer and Strategy Chairman of PricewaterhouseCoopers (PwC). Before retiring he had a successful 30-year career with PwC, holding many leading board and top client roles in the UK and globally as a Senior Partner.

Baroness Joan Hanham CBE (Chairman from September 2014 to August 2015; Non-Executive Director until March 2016)

Baroness Hanham CBE is a Conservative member of the House of Lords, having become a life peer in 1999. From 2010 to 2013, she was Parliamentary Under-Secretary of State at the Department of Communities and Local Government (DCLG), and its Minister in the House of Lords.

She has extensive experience in local government and experience of the health service, having been a member of North West Thames Regional Health Authority and of the Board of Chelsea and Westminster Hospital, a Mental Health Act Commissioner and Chairman of St Mary's NHS Trust.

Jim Mackey (Chief Executive from November 2015 and Chief Executive designate of NHS Improvement)

Jim Mackey is a qualified accountant who joined the NHS in 1990. His previous roles have included Chief Executive of Northumbria Healthcare NHS Foundation Trust, Interim Chief Executive of Northumberland Care Trust, Chief Operating Officer of Northumbria Healthcare NHS Trust, Regional Director of Finance at the Regional Health Authority, Deputy Chief Executive of Northumbria Healthcare NHS Trust, Director of Finance at North Tyneside Healthcare NHS Trust.

He has a keen interest in quality of care, especially patient and family experience, and has participated in a number of reviews and national projects, including the Dalton review in 2014.

Dr David Bennett (Chief Executive to October 2015)

David Bennett's previous roles have included non-political Chief Policy Adviser to Prime Minister Tony Blair; Head of the Policy Directorate and the Strategy Unit in 10 Downing Street; independent adviser to various NHS bodies and senior partner at McKinsey & Company, where he focused on regulated, technology-intensive industries.

Professor the Lord Ara Darzi of Denham (Non-Executive Director from August 2015)

Professor Darzi is Director of the Institute of Global Health Innovation at Imperial College London. He also holds the Paul Hamlyn Chair of Surgery at Imperial College London and the Institute of Cancer Research, and is Executive Chair of the World Innovation Summit for Health in Qatar. He is a Consultant Surgeon at Imperial College Hospital NHS Trust and the Royal Marsden NHS Trust.

Professor Darzi leads a large multidisciplinary team across a diverse and impactful portfolio of academic and policy research. He was knighted for his services in medicine and surgery in 2002 and in 2007 introduced to the House of Lords and appointed Parliamentary Under-Secretary of State at the Department of Health.

He currently sits as a Council Member for the UK's Engineering and Physical Sciences Research Council and has been a member of the Privy Council since June 2009. In January 2016, Professor Darzi was awarded the Order of Merit for exceptionally meritorious service towards the advancement of medicine.

Lord Patrick Carter of Coles (Non-Executive Director from December 2015)

Lord Carter has pursued a successful career in business and in public service. He founded Westminster Health Care in 1985, which he built into a leading provider of care to both the private and public sectors in the UK. He has served on the boards of US and UK healthcare, insurance and technology companies and is currently Chair of Primary Insurance Group. He was Chair of Sport England from 2002 to 2006, Board member of the London 2012 Olympic bid, a Member of HM Treasury's Productivity Panel and a non-executive member of the Home Office and Prisons Boards. He is also Chair of the Department of Health Procurement and Efficiency Board.

Lord Carter has also chaired a number of challenging government reviews including Criminal Records Bureau, Offender Management, the Procurement of Legal Aid, Commonwealth Games 2002, the English National Stadium (Wembley), National

Athletics, Public Diplomacy and Pathology Services. He was made a life peer in 2004.

Sarah Harkness (Non-Executive Director from April 2016)

Sarah Harkness was first appointed to the role of Non-Executive Director of the NHS Trust Development Authority (TDA) in September 2012. Sarah has remained in post to become joint TDA and Monitor Non-Executive Director under the banner of NHS Improvement.

She is an experienced finance professional who has worked at the highest level in a range of roles and organisations. She started her executive career in banking and in 1992 was appointed as Corporate Finance Director of NatWest Markets. Six years later she moved to Arthur Andersen, where she remained until 2002. She left this role to launch the corporate division of Directorbank Executive Search Ltd, which specialised in non-executive recruitment. While there, she took on her own first non-executive roles in the private sector, as Director on the board of Homestyle Group PLC, a financially challenged retailer with an annual turnover of £400 million, and as Chair of McInnes Corporate Finance. She served as Non-Executive Director of Rotherham Priority Health NHS Trust and of NHS North of England. In 2011 she was appointed as Non-Executive Director of JRI Orthopaedics Ltd and now chairs its audit, risk and policy committee. She is also a board adviser to Neyber and pro-chancellor of the University of Sheffield.

Caroline Thomson (Non-Executive Director from April 2016)

Caroline Thomson was first appointed to the role of Non-Executive Director of TDA in May 2013. She has remained in post to become joint TDA and Monitor non-executive director under the banner of NHS Improvement.

She is Chair of Digital UK, the body which is responsible for digital terrestrial television, a Non-Executive Director of VITEC plc (and Chair of the remuneration committee) and of CN media group. She is also a Non-Executive Director of UKGI (formerly the Shareholder Executive) and Chair of its remuneration committee. In the arts world she recently retired as Executive Director of English National Ballet, is Deputy Chair of the National Gallery and a trustee of Tullie House Gallery in Cumbria. She stepped down from her role as Chief Operating Officer (COO) at the BBC in September 2012 after serving 12 years as a member of the Executive Board. As COO she was the Deputy Director General and was responsible for all the non-programme parts of the BBC except finance, including the property portfolio and the negotiation of the Royal Charter and two licence fee settlements.

She received an honorary doctorate from York University in 2013 and was made an honorary fellow of the University of Cumbria in 2015. She is a member of the council of the University of York and a trustee of The Conversation.

Professor Dame Glynis Breakwell DBE DL (Non-Executive Director from April 2016)

Professor Dame Glynis Breakwell DBE DL, Vice-Chancellor of the University of Bath, is one of Europe's leading social psychologists. She is an active public policy adviser and researcher specialising in leadership, identity processes and risk management.

In addition to her role as Vice-Chancellor, Dame Glynis holds a number of senior positions both nationally and internationally, acting as an adviser to the higher education sector, government organisations, multinational corporations and not-for-profit organisations.

Laura Carstensen (Non-Executive Director from April 2016)

Laura Carstensen is a Commissioner of the UK Equality and Human Rights Commission where she has led the recent statutory inquiry into gender diversity on FTSE 350 boards and chairs the Commission's Regulators, Inspectorates and Ombudsmen Forum, which provides guidance and leadership on the role of equalities and human rights.

She is a former partner in the leading international law firm Slaughter and May and, since leaving the firm in 2005, has held a number of public service roles including Deputy Chairman of the Competition Commission and a founder member of the Co-operation and Competition Panel for NHS-Funded Services. She has also served as a foundation trust board member.

She has broad and deep expertise in both sectoral and strategic regulatory policy, underpinned by a commitment to diversity, inclusion and social justice. She is based in the north.

Richard Douglas CB (Non-Executive Director from April 2016)

Richard Douglas CB is the former Director-General (DG) of Finance at the Department of Health and has extensive experience of working across Whitehall.

He retired as DG of finance, commercial and the NHS directorate at the Department of Health in April 2015. He was responsible for ensuring that the department properly managed its finances and those of the health service and accounted to Parliament. He oversaw one of the biggest and most complex accounts consolidations in the world, covering about 700 separate organisations, accounting for almost 7% of UK GDP. He also had primary responsibility for NHS policy and the government's relationship with the NHS. He was DH's sponsor for a number of national arm's length bodies, including NHS England, Monitor and TDA.

He is a member of the Chartered Institute of Public Finance and Accountancy.

Sigurd Reinton CBE (Non-Executive Director from January 2012)

Sigurd Reinton was until 2013 a director of NATS Holdings, which provides the air traffic control services for UK and North Atlantic airspace, and for the main UK airports. At NATS, he served on the Audit and Nominations Committees and chaired the Stakeholder Council.

He was Chairman of the London Ambulance Service NHS Trust for 10 years until 2009 and before that of Mayday University Hospitals NHS Trust. He was a member of the Board of the Ambulance Services Network and of the advisory board of The Foundation. He was a member of the Council of the NHS Confederation from 1998 to 2007 and was the lead for London. He was previously a Director (senior partner) at McKinsey & Company.

Keith Palmer (Non-Executive Director from April 2012 to March 2016)

Keith Palmer is founder and Non-Executive Chairman of AgDevCo, a not-for-profit public-private partnership that supports agricultural development in sub-Saharan Africa. His previous involvement in the health sector includes Non-Executive Director of Guy's and St Thomas' NHS Foundation Trust, Chairman of Barts Health NHS Trust and Senior Associate of the King's Fund and of the Nuffield Trust.

Other positions he has held include Treasurer and Trustee of Cancer Research UK and Vice-Chairman of NM Rothschild merchant bank.

Iain Osborne (Non-Executive Director from May 2014 to March 2016)

Iain Osborne is also Group Director for regulatory policy at the Civil Aviation Authority, and an experienced regulatory expert, having held senior roles in six regulated sectors, privately and publicly funded, at EU, national and regional levels.

His previous roles include Chief Executive of Northern Ireland's energy and water regulator; secondment to the European Commission's competition directorate; and Strategy Director to a pan-European telecoms company.

Heather Lawrence OBE (Non-Executive Director from July 2012 to March 2016)

Heather Lawrence has 23 years' experience as a chief executive including 12 years at Chelsea and Westminster Hospital (2000 to 2012), which gained foundation trust status in 2006. Heather also hosted the North West London (NWL) Collaboration for Leadership in Applied Health Research and Care, set up the NWL Health Innovation Cluster and co-designed the NWL Learning and Education Board.

She chaired the national negotiations for the SAS doctors' contract and Agenda for Change three-year pay deal for non-medical staff. She was a Commissioner for the Prime Minister's Commission for the Future of Nursing and Midwifery, and a member of the Dr Foster Global Comparators Founders Board.

She originally trained as a nurse before qualifying as a teacher and becoming a nurse tutor. She is a Chartered Fellow of the Institute of Personnel Management.

Dr Timothy Heymann (Non-Executive Director from February 2015 to March 2016)

Tim Heymann is a consultant gastroenterologist at Kingston Hospital and Reader in Health Management with the Centre for Health Economics and Management at Imperial College Business School. He is a fellow of the Higher Education Academy and of the Royal College of Physicians of London for whom he is a host examiner.

His previous experience includes: Non-Executive Director, NHS Direct; member, Risk and Regulation Advisory Council; Chair, Information Group of the British Society of Gastroenterology; healthcare consultancy and teaching in Europe, India, the Commonwealth of Independent States, Latin America and Australasia; work in teaching hospitals across London; and management consultancy with McKinsey & Company.

Robert Alexander (Executive Director of Resources/Deputy Chief Executive of NHS Improvement from 1 April 2016)

Robert Alexander was Chief Executive of TDA until 31 October 2015, when he became Deputy Chief Executive. Before this, he served as Director of Finance at TDA. He was appointed Executive Director of Resources/Deputy Chief Executive of NHS Improvement on 1 April 2016.

Before joining TDA in 2012, he was the Finance Director of NHS South of England and the Director of NHS Finance at DH from 2007. There he led on NHS financial policy and performance as well as being responsible for the national tariff programme and finance issues underpinning the health reform programme. He re-entered the NHS as a strategic health authority (SHA) finance director from 2002 to 2007, first with Kent and Medway SHA, then with South East Coast SHA. Before that he held senior financial positions in both the public and private sectors. He is CIPFA qualified.

He is a voting member of the TDA and Monitor Boards.

Stephen Hay (Managing Director, Provider Regulation)

Stephen Hay is Managing Director of Provider Regulation at Monitor, responsible for the monitoring, compliance and intervention regime for NHS foundation trusts. A qualified chartered accountant, he previously worked with KPMG, latterly as a director within the Transaction Services Department. His financial experience is wide ranging and includes mergers and acquisitions, due diligence for initial public offerings and risk assessment.

He joined the DCLG Board as a non-executive director in May 2009 and was Chairman of DCLG's Audit and Risk Committee until December 2014. He continues to be a member of the Audit and Risk Committee.

Adrian Masters (Managing Director, Sector Development)

Adrian Masters joined Monitor in September 2005. His previous roles include Director of the Health Team in the Prime Minister's Delivery Unit and roles at McKinsey & Company, IBM and PwC. He is a qualified accountant with an MBA from Stanford University.

Dr Ruth May (Nursing Director from July 2015)

Before joining Monitor, Ruth May was Regional Chief Nurse and Nurse Director for the Midlands and East region of NHS England. She began her career with a variety of nursing roles before becoming a theatre sister at Frimley Park Hospital. She was Acting Director of Nursing at Barnet Hospital before being appointed the substantive Director of Nursing and Deputy Chief Executive with Havering Primary Care Trust.

In October 2005, she became Chief Executive of The Queen Elizabeth Hospital, King's Lynn, a post which she held for two years. She has also been Chief Executive of Mid Essex Hospital Services NHS Trust. Ruth led 'Stop the Pressure', which nearly halved the number of pressure ulcers in M&E, improving care for patients as well as delivering cost savings to the NHS.

Dr Kathy McLean (Medical Director from April 2016)

Kathy McLean was Medical Director of TDA before being appointed as Medical Director of NHS Improvement on 1 April 2016. Before her appointment as Medical Director of TDA she was the Clinical Transitions Director working with Sir Bruce Keogh building the NHS Commissioning Board, now NHS England. Her work has focused on improving quality by building in clinical leadership and expertise across the system, including development of clinical networks and senates, and she was also a leading member of the NHS Future Forum.

She was Medical Director at East Midlands SHA and before that was Medical Director at Derby Hospitals NHS Foundation Trust, where she was a physician from 1994 until 2009.

She is a voting member of the TDA and Monitor Boards.

Lyn Simpson (Executive Regional Managing Director (North) from April 2016)

Lyn Simpson was Director of Delivery and Development (North) at TDA until 31 March 2016, when she took up the post of Executive Regional Managing Director (North) for NHS Improvement.

Based on an important foundation of nurse, health visitor and midwife posts, she has successfully pursued an extensive and progressive career within the NHS, occupying a series of director and trust board level positions within a range of healthcare settings.

She was Director of Operational Performance and Service Improvement at an SHA for five years before moving to DH to support the Deputy NHS Chief Executive as Director of NHS Operations. She joined TDA to oversee the transition from NHS trust to foundation trust status for organisations in the north.

Dale Bywater (Executive Regional Managing Director (Midlands and East) from April 2016))

Dale Bywater was Director of Delivery and Development (North) at TDA until 31 March 2016, when he took up the post of Executive Regional Managing Director (Midlands and East) for NHS Improvement.

He joined TDA at its beginning in 2012. Before that, he was the National Director of Provider Delivery working within DH. He was Director of Provider Development for the Midlands and East SHA Cluster, having undertaken a similar role previously within NHS East Midlands. Previous SHA roles include Director of Performance, Operations and Commissioning and Director of Planning and Delivery. Before working in an SHA he was National Associate Director leading a number of national programmes, including the development of NHS treatment centres and service improvement programmes to improve day surgery and operating theatre efficiency within the provider sector.

He spent the first 10 years of his career working in a variety of senior operational roles within NHS acute hospitals.

Anne Eden (Acting Executive Regional Managing Director (South) from April 2016

Anne Eden joined TDA as Director of Delivery and Development (South) on 1 April 2015 on secondment from Buckingham Healthcare NHS Trust. On 1 April 2016 she took up the post of Acting Executive Regional Managing Director (South) for NHS Improvement. With more than 30 years' experience in the NHS, she started her career as an NHS management trainee and has experience in acute and teaching hospitals, mental health, community and specialist services.

She joined Buckinghamshire Healthcare NHS Trust as Chief Executive in December 2006. She led the integration of the county's acute and community services in 2010. Previously Director of Clinical Services at Hammersmith Hospitals and Director of Services at St Mary's Hospital, Paddington, she also worked for DH. In 2013 she chaired the Better Training, Better Care group on behalf of Health Education England, which looked at how spending time in and out of hospital settings could help doctors determine their specialist futures.

She has an MBA, is a qualified performance coach and a graduate member of the Institute of Health Services Management and the Chartered Institute of Marketing. In 2012 she became a visiting professor at Buckinghamshire New University and adviser to the faculty of society and health, supporting the Institute of Applied Leadership's MA in Leadership and Management programme.

Executive Committee

Dr David Bennett (Chief Executive) See Board biographies

Miranda Carter (Executive Director, Provider Appraisal)

Miranda joined Monitor in 2004. Her role as Executive Director of Provider Appraisal covers the assessment and authorisation of applicants for NHS foundation trust status, risk assessing significant transactions undertaken by NHS foundation trusts, and developing assessment and transaction policy.

A chartered accountant, Miranda started her career at Deloitte. She joined PwC in 1997 and spent four years in the Transaction Services Department. Her financial experience is wide ranging and includes mergers and acquisitions, due diligence and initial public offerings.

Catherine Davies (Executive Director, Co-operation and Competition)

Catherine Davies joined Monitor on 1 October 2012. She has worked in health since 2009 and came to Monitor from the Co-operation and Competition Panel.

She is a competition law specialist with experience in all aspects of EU and UK competition law, having advised on mergers and acquisitions, joint ventures, distribution arrangements and market investigations across a wide range of sectors, including consumer goods, energy, media and healthcare. Before working in the healthcare sector she worked at the Competition Commission and a large City law firm.

Stephen Hay (Managing Director, Provider Regulation) See Board biographies

Adrian Masters (Managing Director, Sector Development) See Board biographies

Kate Moore (Executive Director, Legal Services)

Kate Moore joined Monitor in September 2004. She is a solicitor with extensive experience of regulatory, litigation and public law gained through her previous roles at City law firms, as Director of Legal at the Investors Compensation Scheme and as a principal consultant with KPMG.

Jeremy Mooney (Executive Director, Strategic Communications)

Jeremy Mooney joined Monitor in January 2015. His career has included extensive experience of corporate communications in both the civil service and in business. As well as working in the telecommunications and IT industry and the outsourced public services sector, he previously spent over nine years as a senior civil servant in Whitehall, first in the NHS Modernisation Agency in the Department of Health, and then as Director of Communication at the Department for Transport.

A serving army reservist, he has completed operational tours in the Balkans and in Afghanistan.

Fiona Knight (Executive Director, Organisation Transformation)

Fiona Knight joined Monitor on 1 July 2013. She has worked in human resources for more than 20 years, including 13 years at KPMG where she was an HR director. Before that, she worked in HR roles within financial services. Her experience includes supporting teams and businesses through change and transition, managing HR integration, employee relations and performance management.

Professor Hugo Mascie-Taylor (Medical Director/Executive Director, Patient and Clinical Engagement)

Hugo Mascie-Taylor joined Monitor on 1 May 2014. He has a strong clinical background, having worked in the NHS as a clinical director, medical director and a director of commissioning, including Executive Medical Director of Leeds Teaching Hospitals Trust (which involved periods acting as Chief Executive) and Medical Director at the NHS Confederation.

He was Trust Special Administrator at Mid Staffordshire NHS Foundation Trust, working to ensure that services at Cannock Chase and Stafford Hospitals continue to operate for patients into the future.

Adam Sewell-Jones (Executive Director, Provider Sustainability)

Adam Sewell-Jones joined Monitor on 8 August 2015. He has 23 years' experience in the NHS and was most recently Deputy Chief Executive at Basildon and Thurrock University Hospitals NHS Foundation Trust, where he had responsibility for strategy and the transformation programme, which underpinned a wide range of service developments to improve the quality of the healthcare services provided.

A qualified accountant, he has held a range of roles at Basildon including Director of Finance, Chief Operating Officer and General Manager of Medicine, and worked in finance roles at trusts including University College London Hospitals and Redbridge Healthcare.

Register of interests

A register of interests of Board members is maintained by the Secretary to the Board and is available on NHS Improvement's website.

Employment and staff engagement

Details on employment policy, equality and diversity and staff engagement can be found in the Performance report on pages 41 and 42.

Sickness absence

The average time taken as sick leave by Monitor employees in 2015/16 was 2.8 days (2014/15: 3.7 days).

Pension liabilities

The treatment of pension liabilities is disclosed in Note 3 to the financial statements.

Management of information risk and personal data related incidents

Monitor seeks to minimise the risk of a serious incident requiring investigation arising from the misuse of personal or sensitive data. To this end, Monitor has an information governance policy, an information and data handling policy and an incident management and reporting procedure to aid in the identification and management of Monitor's exposure to risk in relation to any of its data processing activities. There were no incidents of personal data being lost or stolen in 2015/16, reportable to the Information Commissioner's Office or otherwise.

Remuneration report

Remuneration policy

The remuneration of Monitor employees, including the Chief Executive, is agreed or ratified by the Remuneration Committee, while the Chairman's salary is determined by the Secretary of State for Health. The membership of the Remuneration Committee comprises the Deputy Chairman of Monitor, a non-executive director and other members as from time to time agreed by the Chairman of the committee. Other non-executive directors attend by invitation. No member is involved in any decisions or discussion as to their own remuneration. In reaching its recommendations, the committee has regard for the following considerations:

- the Department of Health pay remit guidance
- the need to recruit, retain and motivate suitably able and qualified staff
- the funds available from the Department of Health
- the requirement to deliver performance targets.

In April 2015, the Senior Salaries Review Body made certain recommendations on very senior manager (VSM) salaries. These recommendations were partially or fully accepted by the government, but the Remuneration Committee agreed to no annual increment to VSM salaries in 2015/16.

Service contracts

Appointments are made on merit on the basis of fair and open competition. Unless otherwise stated, the executive team covered by this report holds appointments which are open-ended.

Staff report

As at 31 March 2016 the composition of all staff was as follows. The figures in Table 16 include staff on payroll, secondees and temporary staff.

Table 16: Staff composition

	Female	Male
Directors, including senior civil service equivalents	36	51
Employees	297	250
Total number of employees	333	301

See Note 3 to the accounts for details on staff costs and Note 4 to the accounts for details on non-pay expenditure, including professional services and consultancy.

For sickness absence data, see page 80; for staff policies, including equality and diversity, see pages 41 to 42.

Notice periods and termination costs

The required notice periods for the executive team are given in Table 17. Under the terms of their contract, after one continuous year of service, executive team members are eligible for the same severance payment as any other Monitor employee, which is determined by the civil service severance compensation scheme.

Table 17: Executive team notice periods

	Notice period
Jim Mackey, Chief Executive	2 months*
Stephen, Hay Managing Director, Provider Regulation	6 months
Adrian Masters, Managing Director, Sector Development	6 months
Miranda Carter, Executive Director, Provider Appraisal	3 months
Catherine Davies, Executive Director, Co-operation and Competition	3 months
Fiona Knight, Executive Director, Organisational Transformation	3 months
Hugo Mascie-Taylor, Executive Director, Patient and Clinical Engagement	3 months
Jeremy Mooney, Executive Director, Strategic Communications	3 months
Kate Moore, Executive Director, Legal Services	3 months
Adam Sewell-Jones Executive Director, Provider Sustainability	3 months

*Jim Mackey's notice period at Northumbria Healthcare NHS Foundation Trust is two months; during the period of his secondment his notice period has not changed.

Salary and pension entitlements

The following sections provide details of the remuneration and pension interests of Monitor's executive team and Board. These figures are subject to audit. Senior managers are salaried and are entitled to annual pay progression subject to individual performance against objectives.

Table 18: Salary, benefits in kind and pension benefits

	Salary (£000)		Benefits in kind (to nearest £100)[1]		Pension benefits (£000)		Total (£000)	
	2015/16	2014/15	2015/16	2014/15	2015/16	2014/15	2015/16	2014/15
David Bennett Chief Executive (until October 2015)	180-185	230-235	-	100	N/A	N/A	180-185	230-235
Jim Mackey Chief Executive[2] (from November 2015)	50-55	N/A	2,000	N/A	N/A	N/A	50-55	N/A

	Salary (£000)		Benefits in kind (to nearest £100)[1]		Pension benefits (£000)		Total (£000)	
Stephen Hay Managing Director, Provider Regulation[3]	190-195	190-195	-	100	65	59	255-260	250-255
Adrian Masters Managing Director, Sector Development	165-170	165-170	-	0	56	49	220-225	210-215
Miranda Carter Executive Director, Provider Appraisal	130-135	130-135	-	0	56	32	185-190	160-165
Catherine Davies Executive Director, Co-operation and Competition	125-130	130-135	-	0	N/A	N/A	125-130	130-135
Fiona Knight Executive Director, Organisational Transformation	170-175	120-125	-	0	47	45	215-220	165-170
Hugo Mascie-Taylor Executive Director, Patient and Clinical Engagement (from May 2014)	195-200	115-120	-	0	N/A	N/A	195-200	115-120
Jeremy Mooney Executive Director, Strategic Communications (from January 2015)	125-130	25-30	-	0	49	10	175-180	35-40
Kate Moore Executive Director, Legal Services	130-135	130-135	-	0	45	45	175-180	175-180
Adam Sewell-Jones Executive Director, Provider Sustainability[4] (from August 2015)	95-100	N/A	7,600	N/A	38	N/A	140-145	N/A

Notes on Table 18

1. Benefits in kind are the taxable value of benefits provided. The values are calculated in accordance with Inland Revenue rules and relate to the salary sacrifice car schemes.

2. Jim Mackey is on secondment from Northumbria Healthcare NHS Foundation Trust from 1 November 2015 to 31 October 2017 as the joint Chief Executive of Monitor and the NHS Trust Development Authority. The amount above is the effective salary for Monitor during 2015/16. Jim Mackey left the NHS Pension Scheme on 1 October 2010. Salary disclosed comprises two elements: his salary for five months within the band of £45,000 to £50,000 and a payment in lieu of employer's contributions to the NHS Pension Scheme within the band £5,000 to £10,000. His full-time annualised salary is within the band £215,000 to £220,000, and his payment in lieu of

employer's pension contributions is within in the band £25,000 to £30,000, of which 50% is attributable to his Monitor duties. VAT is payable on secondments into Monitor. The annual report of Northumbria Healthcare NHS Foundation Trust discloses Jim Mackey's remuneration and pension interests before November 2015.

3. Stephen Hay has Board-level responsibility for finance.

4. Adam Sewell-Jones was seconded from Basildon and Thurrock University Hospitals NHS Foundation Trust from May 2015 to July 2015. The trust was reimbursed £21,000 by Monitor for this secondment; this amount includes VAT as it is not recoverable by Monitor. The full-time annualised salary is within the band £145,000 to £150,000.

Total remuneration includes salary, benefits in kind and severance payments. There is no performance-related pay. It does not include employer pension contributions and the cash equivalent transfer value (CETV) of pensions.

The value of pension benefits accrued during the year is calculated as (the real increase in pension multiplied by 20) less (the contributions made by the individual). The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

Pay multiples

Reporting bodies are required to disclose the relationship between their highest paid director's remuneration and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in Monitor in the financial year 2015/16 was £230,000 to £235,000 (31 March 2015, £230,000 to £235,000). This was 3.8 times (31 March 2015, 3.8) the median full-time equivalent (FTE) remuneration of the workforce at 31 March 2016, which was £61,206 (31 March 2015, £60,600).

The median remuneration figures include permanent staff on payroll, including substantive secondments.

In 2015/16 no employees received remuneration in excess of the highest paid director (2014/15: zero). Remuneration ranged from £20-25,000 to £230-235,000 (2014/15 £20-25,000 to £230-235,000).

Chairman and other non-executive directors

All remuneration paid to the Chairman and non-executive directors is non-pensionable. The benefits in kind given to executive and non-executive directors are disclosed in Table 19. The monetary value of benefits in kind covers any payments (for business expenses or otherwise) or other benefits provided by Monitor that are treated by HM Revenue & Customs as a taxable emolument.

Table 19: Benefits in kind for non-executive directors

	Salary claimed (£000)		Benefits in kind (to nearest £100)		Total (£000)	
	2015/16	2014/15	2015/16	2014/15	2015/16	2014/15
Baroness Joan Hanham Chair (until July 2015) and Non-Executive Director (until March 2016)*	40-45	60-65	0	1800	40-45	60-65
Ed Smith Chair (from August 2015)**	20-25	N/A	0	N/A	20-25	N/A
Sigurd Reinton Non-Executive Director	15-20	15-20	0	400	15-20	15-20
Keith Palmer Non-Executive Director (until March 2016)	0-5	5-10	0	100	0-5	5-10
Heather Lawrence Non-Executive Director (until March 2016)	0-5	10-15	400	800	0-5	10-15
Iain Osborne Non-Executive Director (until March 2016)	5-10	5-10	0	100	5-10	5-10
Timothy Heymann Non-Executive Director (until March 2016)	5-10	0-5	0	0	5-10	0-5
Lord Carter Non-Executive Director (from February 2016)	0-5	N/A	0	N/A	0-5	N/A
Lord Darzi Non-Executive Director (from August 2015)	5-10	N/A	0	N/A	5-10	N/A

*Salary disclosed above for Baroness Joan Hanham includes a payment made in August in the band £15-20k. This was analogous to a payment in lieu of notice and was made in line with Secretary of State instruction.

**Ed Smith was appointed Chair of Monitor from July 2015 and joint Chair designate of NHS Improvement from October 2015. He was paid a total of £40,000 to £45,000 during 2015/16 for performing these roles. Table 19 shows the effective salary for Monitor; £21,000 including VAT has been recharged to the NHS Trust Development Authority. The annualised full-time equivalent salary is £100,000 to £105,000.

Table 20: Executive directors' pensions and cash equivalent transfer values (CETV)

	Accrued pension at pension age as at 31 March 2016 and related lump sum	Real increase in pension and related lump sum at pension age	CETV at 31 March 2016	CETV at 31 March 2015	Real increase in CETV
	£000	£000	£000	£000	£000
Stephen Hay Managing Director, Provider Regulation	35-40	2.5-5	641	533	49
Adrian Masters Managing Director, Sector Development	35-40	2.5-5	580	473	39
Miranda Carter Executive Director, Provider Appraisal	25-30	2.5-5	363	301	25
Fiona Knight Executive Director, Organisational Transformation	5-10	2.5-5	111	66	28
Jeremy Mooney Executive Director, Strategic Communications	0-5	2.5-5	52	8	34
Kate Moore Executive Director, Legal Services	25-30	2.5-5	486	400	36
Adam Sewell-Jones Executive Director, Provider Sustainability (from August 2015)	0-5	0-2.5	22	N/A	15

Jim Mackey is on secondment from Northumbria Healthcare NHS Foundation Trust from 1 November 2015 to 31 October 2017 as the joint Chief Executive of Monitor and the NHS Trust Development Authority. He left the NHS Pension Scheme on 1 October 2010.

David Bennett, Chief Executive until October 2015, and Hugo Mascie-Taylor, Executive Director, Patient and Clinical Engagement, did not receive pensions on their salary.

Catherine Davies, Executive Director, Co-operation and Competition, is a member of a partnership pension scheme. During 2015/16 Monitor made contributions of £20,700 on her behalf (figures given to the nearest £100).

None of the executive team are members of a scheme which automatically pays a lump sum on retirement.

Table 21: Exit packages for 2015/16

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	-	-	-
£10,00 – £25,000	-	-	-
£25,001 – £50,000	-	1	1
£50,001 – £100,000	-	1	1
£100,000 – £150,000	-	-	-
£150,001 – £200,000	-	-	-
Total number of exit packages by type	-	2	2
Total resource cost	-	£93,042	£93,042

No exit packages were paid during 2014/15

David Bennett received payment in lieu of unexpired notice in October 2015 in the range £40,000 to £45,000.

Fiona Knight was offered payments within the Civil Service Compensation Scheme in March 2016 with a compensation payment due of £25,000 to £30,000. Additional early retirement costs are estimated at £20,000 to £25,000.

Details of off-payroll engagements

Following the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, Monitor must publish information on highly paid and/or senior off-payroll engagements. The information contained in the tables below includes all off-payroll engagements as at 31 March 2016 for more than £220 per day and that last longer than six months for Monitor. All such appointments have been subject to a risk-based assessment regarding the payment of correct tax.

Table 22: Off-payroll engagements at 31 March 2016

All off-payroll engagements as at 31 March 2016 which are more than £220 per day and last for longer than six months	
Number of existing engagements as of 31 March 2016	25
Of which...	
Number that have existed for less than one year at time of reporting	19
Number that have existed for between one and two years at time of reporting	6
Number that have existed for between two and three years at time of reporting	-
Number that have existed for between three and four years at time of reporting	-
Number that have existed for four or more years at time of reporting	-

All new off-payroll engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016, for more than £220 per day and that last for longer than six months	
Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	21
Number of the above which include contractual clauses giving Monitor the right to request assurance in relation to income tax and National Insurance obligations	21
Number for whom assurance has been requested	21
Of which…..	
Number for whom assurance has been received	21
Number for whom assurance has not been received	-
Number that have been terminated as a result of assurance not being received	-

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2015 and 31 March 2016	
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	1*
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure **must** include both off-payroll and on-payroll engagements	25

*The one Board member engaged off-payroll is Jim Mackey, who is on secondment from Northumbria Healthcare NHS Foundation Trust from 1 November 2015 to 31 October 2017 as the joint Chief Executive of Monitor and the NHS Trust Development Authority. He is on Northumbria Healthcare NHS Foundation Trust's payroll, and Monitor is recharged for his costs of employment.

Pension liabilities

The treatment of pension liabilities is disclosed in Note 3 to the financial statements.

Civil service pensions

Pension benefits are provided through the civil service pension arrangements. Further details of Monitor's pension arrangements can be found in Note 3 to the accounts.

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capitalised value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. The CETV is the amount paid by one pension scheme or arrangement to secure pension benefits in another pension scheme or

arrangement when a pension scheme member leaves and chooses to transfer the benefits accrued from their previous scheme.

The pension figure shown relates to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefit in another scheme or arrangement which the individual has transferred to the civil service pension arrangements and for which the civil service vote has received a transfer payment commensurate with the additional pension liabilities being assumed. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries and do not take account of any actual or potential reduction to benefits resulting from Lifetime Allowance Tax which may be due when pension benefits are drawn.

Real increase in cash equivalent transfer values

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

The Parliamentary accountability and audit report on page 92 forms part of the Accountability Report.

Jim Mackey
Chief Executive
4 July 2016

Parliamentary accountability and audit report

Regularity of expenditure

The income and expenditure recorded in the financial statements have been applied to the purposes intended by Parliament, and the financial transactions recorded in the financial statements conform to the authorities given to Monitor. This information is subject to audit opinion.

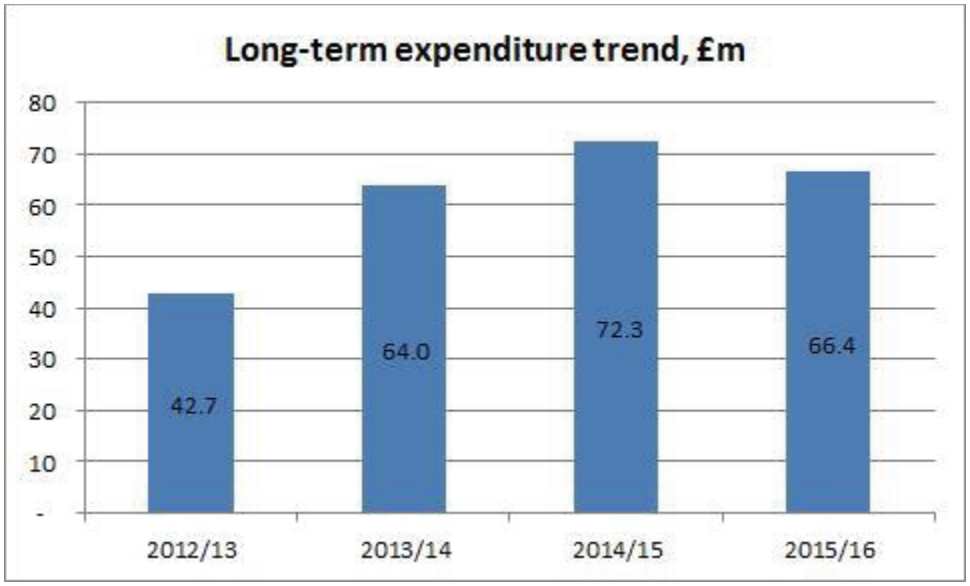
Cost allocation and charges for information

In the event of Monitor charging for services provided, Monitor will pass on the full cost for providing the services in line with HM Treasury guidance.

Long-term expenditure trend

Figure 1 shows the trend in net expenditure since financial year 2012/13; Monitor's expenditure during this period reflects the statutory duties set out in the Health and Social Care Act 2012.

Figure 1: Trend in net expenditure since financial year 2012/13



Certificate and Report of the Comptroller and Auditor General to the Houses of Parliament

Opinion on financial statements

In my opinion the financial statements:

- give a true and fair view of the state of Monitor's affairs as at 31 March 2016 and of the net expenditure for the year then ended
- have been properly prepared in accordance with the Health and Social Care Act 2012 and Secretary of State directions issued thereunder.

Opinion on regularity

In my opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Basis of opinions

I have audited the financial statements of Monitor for the year ended 31 March 2016 under the Health and Social Care Act 2012. The financial statements comprise the:

- Statement of comprehensive net expenditure
- Statement of financial position
- Statement of cash flows
- Statement of changes in taxpayers' equity and
- the related notes.

These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Accountability and Remuneration Reports that is described as having been audited.

The basis of my regularity opinion is the regularity framework which comprise the Health and Social Care Act 2012, Managing Public Money and applicable law.

Overview of my audit approach

Risks significant to my audit

My audit approach is risk-based, informed by a good understanding of the operations of Monitor and an assessment of the risks associated with the financial statements and the regularity of underlying transactions. This approach focuses effort towards higher risk areas, such as management judgements and estimates and those that are considered significant based upon size, complexity and risk.

Those risks that had the greatest effect on my overall audit strategy, the allocation of resources in my audit and directing the efforts of the audit team in the current year are documented below.

I have also set out how my audit addressed these specific areas in order to support the opinion on the financial statements as a whole, and any comments I make on the results of my procedures should be read in this context.

Risk	My response
Segmental reporting of ring-fenced expenditure: In addition to its core revenue budget Monitor has three ring-fenced budgets to support its work on Contingency Planning, Trust Special Administration and Special Measures. There was a risk that these ring-fenced budgets could be applied to core expenditure without prior authorisation from the Department of Health, which would impact my opinion on regularity.	To address this risk I assessed Monitor's control and monitoring procedures over expenditure from ring fenced budgets. I also performed direct testing on transactions recorded in each of Monitor's reportable segments. I carried out this work to enable me to verify whether or not amounts had been reported and classified appropriately. I also assessed whether Monitor had made any transfers from its ring fenced budgets and, if so, whether or not any such transfers had been properly authorised. I am satisfied that this risk has not materialised.
Management Override of control: International Standard on Auditing (UK and Ireland) 240 The auditor's responsibilities relating to fraud in an audit of financial statements states that there is a risk in all entities that management override controls to perpetrate fraud. The standard requires that auditors perform audit procedures to address this risk in the following areas: • Journal entries • Bias in accounting estimates and • Significant unusual transactions.	I identified a risk because International Standards on Auditing (UK and Ireland) require that I consider this risk. I reviewed a sample of journals for appropriateness and considered management's accounting estimates and significant judgements for evidence of bias. I also included an element of unpredictability in our testing plans. I am satisfied that this risk has not materialised.

Application of materiality

I applied the concept of materiality in both planning and performing my audit, and in evaluating the effect of misstatements on my audit and on the financial statements. This approach recognises that financial statements are rarely absolutely correct, and that an audit is designed to provide reasonable, rather than absolute, assurance that the financial statements are free from material misstatement or irregularity. A matter

is material if its omission or misstatement would, in the judgement of the auditor, reasonably influence the decisions of users of the financial statements.

Based on my professional judgement, I determined overall materiality for Monitor's financial statements at £1,330,060 which is approximately 2% of gross expenditure, a benchmark that I consider to be the principal consideration for users in assessing the financial performance of Monitor.

As well as quantitative materiality there are certain matters that, by their very nature, would, if not corrected influence the decisions of users, for example, any errors reported in the Remuneration Report. Assessment of such matters would need to have regard to the nature of the misstatement and the applicable legal and reporting framework, as well as the size of the misstatement.

I applied the same concept of materiality to my audit of regularity. In planning and performing audit work in support of my opinion on regularity and evaluating the impact of any irregular transactions, I took into account both quantitative and qualitative aspects that I consider would reasonably influence the decisions of users of the financial statements.

I agreed with the Audit and Risk Committee that I would report to it all uncorrected misstatements identified through my audit in excess of £16,000 (this was later reduced to £13,000 as a result of updated materiality), as well as differences below this threshold that in my view warranted reporting on qualitative grounds.

There are no unadjusted audit differences.

Scope of my audit

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to Monitor's circumstances and have been consistently applied and adequately disclosed
- the reasonableness of significant accounting estimates made by the directors and
- the overall presentation of the financial statements.

In addition I read all the information and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

I am also required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Other matters on which I report

In my opinion:

- the parts of the Remuneration Report and the Parliamentary accountability and audit report to be audited have been properly prepared in accordance with directions made by the Secretary of State under the Health and Social Care Act 2012 and
- the information given in Performance Report and Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept or returns adequate for my audit have not been received from branches not visited by my staff or
- the financial statements and the parts of the Remuneration and Staff Report and the Parliamentary Accountability disclosures to be audited are not in agreement with the accounting records and returns or
- I have not received all of the information and explanations I require for my audit or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Consistency of information in the Annual Report

Under International Standards on Auditing (UK & Ireland), I am required to report to you if, in my opinion, information in the annual report is:

- materially inconsistent with the information in the audited financial statements or
- apparently materially incorrect based on, or materially inconsistent with, the knowledge of Monitor that I acquired in the course of performing my audit or
- otherwise misleading.

In particular, I am required to consider:

- whether I have identified any inconsistencies between the knowledge that I acquired during the audit and the directors' statement that they consider the annual report is fair, balanced and understandable; and

- whether the annual report appropriately discloses those matters that I communicated to the Audit and Risk Committee which I consider should have been disclosed.

I have nothing to report arising from this duty.

The directors' assessment of principal risks and future prospects

Under International Standards on Auditing (UK & Ireland), I am required to report to you if I have anything material to add, or to draw attention to, in relation to the directors' disclosures in the annual report and financial statements:

- confirming that they have carried out a robust assessment of the principal risks facing Monitor, including those that would threaten its business model, future performance, solvency or liquidity
- describing those risks and explaining how they are being managed or mitigated
- on whether they considered it appropriate to adopt the going concern basis, and their identification of any material uncertainties to the entity's ability to continue over a period of at least twelve months from the date of approval of the financial statements and
- explaining how they have assessed the prospects of the entity, over what period they have done so and why they consider that period to be appropriate, and their statement as to whether they have a reasonable expectation that Monitor will be able to continue in operation and meet its liabilities as they fall due over the period of their assessment, including any related disclosures drawing attention to any necessary qualifications or assumptions.

I have nothing material to add, or to draw attention to, on these matters.

Respective responsibilities of the Accounting Officer and the auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of Monitor's financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and with International Standards on Auditing (UK & Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Sir Amyas C E Morse
Comptroller and Auditor General
National Audit Office
157-197 Buckingham Palace Road
London, SW1W 9SP

8 July 2016

Monitor annual accounts 2015/16

These accounts reflect the operations of Monitor. Monitor was originally established in January 2004 under the Health and Social Care (Community Health and Standards) Act 2003 and it continues under the Health and Social Care Act 2012. Monitor has responsibility for authorising, monitoring and regulating NHS foundation trusts and, in addition, it has been assigned the role of sector regulator for healthcare services under the Health and Social Care Act 2012. Monitor is accountable to Parliament and independent of government.

Further information on Monitor's role can be found on page 7 of this report.
In accordance with the provisions of Schedule 8 of the Health and Social Care Act 2012, these accounts have been prepared in a form directed by the Secretary of State. These accounts cover the year ended 31 March 2016.

Statement of comprehensive net expenditure
for the year ended 31 March 2016

	Note	year ended 31-03-16 £000's	£000's	year ended 31-03-15 £000's	£000's
Expenditure					
Staff costs	3	(49,226)		(39,455)	
Depreciation and amortisation	4	(2,524)		(1,442)	
Other expenditure	4	(14,757)		(31,356)	
Total expenditure			(66,507)		(72,253)
Income					
Miscellaneous income	5		97		1
Net expenditure			(66,410)		(72,252)
Comprehensive net expenditure for the year			**(66,410)**		**(72,252)**

All operations are continuing.

There were no other recognised gains or losses for the financial year.

The notes on pages 103 to 113 form part of these accounts.

Statement of financial position
as at 31 March 2016

	Note	31-03-16 £000's	31-03-16 £000's	31-03-15 £000's	31-03-15 £000's
Non-current assets					
Intangible assets	7a		6,091		4,438
Property, plant and equipment	7b		2,212		2,555
Total non-current assets			8,303		6,993
Current assets					
Trade and other receivables	8	728		815	
Cash and cash equivalents	9	7,991		7,913	
Total current assets			8,719		8,728
Total assets			17,022		15,721
Current liabilities					
Trade and other payables	10	(10,202)		(13,191)	
Total current liabilities			(10,202)		(13,191)
Non-current assets plus net current assets			6,820		2,530
Assets less liabilities			**6,820**		**2,530**
General reserve			**6,820**		**2,530**

The notes on pages 103 to 113 form part of these accounts.

Jim Mackey
Chief Executive
4 July 2016

Statement of cash flows
for the year ended 31 March 2016

	Note	31/03/2016 £000's	31/03/2015 £000's
Cash flows from operating activities			
Net expenditure on ordinary activities		(66,410)	(72,252)
Adjustments for non-cash items			
Depreciation charge	4	1,191	940
Amortisation charge	4	1,333	502
Loss on disposals	4	0	3
Adjustments for movements on working capital			
Decrease in trade and other receivables falling due within one year	8	87	111
Increase/(Decrease) in trade and other payables falling due within one year	10	(2,856)	757
Net cash outflow from operating activities		(66,655)	(69,939)
Cash flows from investing activities			
Payments to acquire intangible non-current assets	7a	(3,119)	(3,431)
Payments to acquire property, plant and equipment	7b	(848)	(1,055)
Cash flows from financing activities			
Grant-in-aid from Department of Health		70,700	63,700
Net increase/(Decrease) in cash and cash equivalents		**78**	**(10,725)**
Cash and cash equivalents at the beginning of the year	9	7,913	18,638
Cash and cash equivalents at the end of the year	9	7,991	7,913

The notes on pages 103 to 113 form part of these accounts.

Statement of changes in taxpayers' equity
for the year ended 31 March 2016

	General Reserve 2015/16 £000's	General Reserve 2014/15 £000's
Balance at 1 April	**2,530**	**11,082**
Comprehensive net expenditure for the year	(66,410)	(72,252)
Grant-in-aid received towards revenue expenditure	66,866	59,664
Grant-in-aid received towards purchase of non-current assets	3,834	4,036
Balance at 31 March	**6,820**	**2,530**

Notes to the Accounts

1. Accounting policies

The financial statements have been prepared in accordance with the 2015/16 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of Monitor for the purpose of giving a true and fair view has been selected. The particular policies adopted Monitor are described below. They have been applied consistently in dealing with items that are considered material to the accounts.

Accounting convention

This account is prepared under the historical cost convention, in accordance with directions issued by the Secretary of State for Health with the approval of HM Treasury.

Going concern

Monitor's accounts are produced on a going concern basis. The Department of Health has approved Monitor's 2016/17 budget, and Monitor will continue to be financed by the Department through grant-in-aid.

Non-current assets

Monitor has determined that current value is not materially different from historical cost and has therefore chosen to value property, plant and equipment, and intangible assets at historical cost.

Intangible assets comprise purchased licences to use third party software systems. All assets falling into this category with a value of £5,000 or more have been capitalised. Intangible assets are valued at historical cost less amortisation.

Assets under construction comprises assets currently being built and not yet in use. Assets under construction are not amortised.

Property, plant and equipment comprises IT hardware, furniture, fixtures, office equipment and leasehold improvements which individually or grouped cost more than £5,000. Tangible assets are valued at historical cost less depreciation.

Assets of the same or similar type acquired around the same time and scheduled for disposal around the same time, or assets which are purchased at the same time and are to be used together, are grouped together as if they were individual assets.

Amortisation and depreciation

Amortisation and depreciation is provided from the month after the asset is ready for use at rates calculated to write off the cost or valuation of each asset evenly over its expected life as follows:

IT Software and IT Equipment - 3 years
Furniture, fixtures and office equipment - 5 years

Income & Funding

The main source of funding for Monitor is Government grant-in-aid from the Department of Health. This is credited to the general reserve as it is received. In addition, Monitor receives income as a result of some of its operating activities, for example outward secondment. Miscellaneous operating income is recognised on the face of the *Statement of comprehensive net expenditure* and is accrued for using the accruals convention.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term.

1. Accounting policies continued

Value Added Tax
Monitor is registered for VAT however HM Revenue & Customs have determined that only a very limited amount of input VAT can be reclaimed. Expenditure in these accounts is shown inclusive of irrecoverable VAT.

Pensions
Monitor participates in the Principal Civil Service Pension Scheme. The scheme is an unfunded defined benefit scheme. Monitor contributes annual premiums and retains no further liability except in the case of employees who take early retirement. Employers pension cost contributions are charged to operating expenses as and when they become due. Details are included in note 3 to the Accounts.

Special measures buddy trust reimbursements and incentive payments

Partnership organisations that have been appointed to provide support to trusts in special measures ("buddy trusts") are eligible to receive reimbursement of expenses in delivering an agreed programme of support. These reimbursement payments are recognised as an expense in accordance with the corresponding Memorandum of Understanding for each arrangement.

Buddy trusts are also potentially eligible for an incentive payment up to twice the reimbursement cost total; this is subject to criteria based on the benefits delivered by each programme of work. Incentive payments are recognised as an expense in the accounts when it becomes probable that the eligibility criteria have been met.

1. Accounting policies continued

Early adoption of IFRSs, amendments and interpretations

Monitor has not adopted any IFRSs, amendments or interpretations early.

IFRSs, amendments and interpretations in issue but not yet effective, or adopted

Change published	Financial year for which the change first applies
IFRS 11 (amendment) – acquisition of an interest in a joint operation	Not yet EU adopted. Expected to be effective from 2016/17.
IAS 16 (amendment) and IAS 38 (amendment) – depreciation and amortisation	Not yet EU adopted. Expected to be effective from 2016/17.
IAS 16 (amendment) and IAS 41 (amendment) – bearer plants	Not yet EU adopted. Expected to be effective from 2016/17.
IAS 27 (amendment) – equity method in separate financial statements	Not yet EU adopted. Expected to be effective from 2016/17.
IFRS 10 (amendment) and IAS 28 (amendment) – sale or contribution of assets	Not yet EU adopted. Expected to be effective from 2016/17.
IFRS 10 (amendment) and IAS 28 (amendment) – investment entities applying the consolidation exception	Not yet EU adopted. Expected to be effective from 2016/17.
IAS 1 (amendment) – disclosure initiative	Not yet EU adopted. Expected to be effective from 2016/17.
Annual improvements to IFRS: 2012-15 cycle	Not yet EU adopted. Expected to be effective from 2017/18.
IFRS 9 Financial Instruments	Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 15 Revenue from contracts with customers	Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 16 Leases	Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 14 Regulatory Deferral Accounts	Not yet EU-endorsed.

None of these new or amended standards and interpretations are likely to be applicable or are anticipated to have future material impact on the financial statements of Monitor.

2. Analysis of net expenditure by segment

Monitor has chosen to divide its activities into four reportable segments. These segments are used by Monitor's executive to manage and report expenditure throughout the year.

Segment 1: Monitor's core running costs. Monitor's core responsibilities are to make sure:
- public providers are well led;
- essential services are maintained;
- the NHS payment system promotes quality and efficiency; and
- procurement, choice and competition operate in the best interest of patients.

Segment 2: Contingency planning work (CPT). During 2015/16 this activity has been increasingly delivered using in house staff rather than external suppliers, and the volume of activity has decreased leading to a reduction in spend since 2014/15.

Segment 3: Trust Special Administration work (TSA). Costs of TSA in 2015/16 represent the administration of the shell Mid Staffordshire NHS Foundation Trust.

Segment 4: Special Measures buddying. Trusts in special measures can enter into partnership ("buddy") arrangements with other providers to provide advice and support. The costs reported here reflect the reimbursement of buddy trust costs and eligible incentive payments.

2015/16	Core running costs	CPT	TSA	Special measures	Total
	£000's	£000's	£000's	£000's	£000's
Gross expenditure	60,179	4,180	21	2,127	66,507
Income	(97)	0	0	0	(97)
Net expenditure	**60,082**	**4,180**	**21**	**2,127**	**66,410**

2014/15	Core running costs	CPT	TSA	Special measures	Total
	£000's	£000's	£000's	£000's	£000's
Gross expenditure	54,111	8,621	7,402	2,119	72,253
Income	(1)	0	0	0	(1)
Net expenditure	**54,110**	**8,621**	**7,402**	**2,119**	**72,252**

Assets and liabilities are not reported to management in the segments above, so all are deemed to relate to core running costs.

3. Staff costs

a) Staff costs comprise the following

2015/16	Permanently employed staff £000's	Others £000's	Total £000's
Salaries and wages	33,276	5,726	39,002
Social security costs	3,485	0	3,485
Employer's pension costs	7,095	0	7,095
Total cost of staff employed	**43,856**	**5,726**	**49,582**
Less recoveries in respect of outward secondments	(356)	0	(356)
Total cost of staff	**43,500**	**5,726**	**49,226**
Average number of whole-time equivalent persons employed during the year	515	56	571

2014/15	Permanently employed staff £000's	Others £000's	Total £000's
Salaries and wages	25,940	5,308	31,248
Social security costs	2,759	0	2,759
Employer's pension costs	5,513	0	5,513
Total cost of staff employed	**34,212**	**5,308**	**39,520**
Less recoveries in respect of outward secondments	(65)	0	(65)
Total cost of staff	**34,147**	**5,308**	**39,455**
Average number of whole-time equivalent persons employed during the year	419	47	466

Other staff costs consist of agency, interim and seconded staff.

Monitor participates in the Principal Civil Service Pension Scheme (PCSPS). The Scheme is an unfunded, multi-employer defined benefit scheme in which Monitor is unable to identify its share of the underlying assets and liabilities. A full actuarial valuation was carried out as at 31 March 2012. Details can be found in the resource accounts of the Cabinet Office: Civil Superannuation (www.civilservice-pensions.gov.uk).

For 2015/16, employer's contributions of £6,835,047 were payable to the PCSPS (2014/15: £5,336,240) at one of four rates in the range of 20.0% and 24.5% of pensionable pay, based on salary bands. The Scheme Actuary reviews employer contributions every four years following a full scheme valuation. The contribution rates are set to meet the cost of the benefits accruing during 2015/16 to be paid when the member retires and not the benefits paid during this period.

Employees can opt to open a partnership pension account, a stakeholder pension with an employer contribution. Employer's contributions of £329,382 (2014/15: £258,938) were paid into one or more of a panel of three appointed stakeholder pension providers. Employer contributions are age-related and range from 4.5% to 17.8% of pensionable pay. Employers also match employee contributions up to 3% of pensionable pay. In addition, employer contributions of £15,290 (2014/15: £20,128), 0.5% of pensionable pay, were payable to the pension providers to cover the cost of the future provision of lump sum benefits on death in service and ill health retirement of these employees. Contributions due to the partnership pension providers at the 31 March 2016 were £34,562 (31 March 2015: £27,375).
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b) Reporting of Civil Service and other compensation schemes - exit packages

There are £93,042 of exit costs recorded within the accounts in 15/16, please see the Remuneration Report for more details (2014/15: NIL).

c) The salaries of executives and NEDs are disclosed in the Remuneration Report.

4. Other operating expenditure

	31-03-16 £000's	31-03-15 £000's
Core running costs		
Office expenses	4,660	3,648
Property expenses	1,907	1,374
Pricing development spend	625	2,731
Costing and coding assurance	1,515	1,262
Audit fee for Monitor	45	45
Audit fee for consolidated accounts of NHS foundation trusts	68	68
Other professional services	1,520	3,076
Travel and subsistence	570	442
Communication expenses	498	411
General expenses	200	221
Non-cash items		
Depreciation and amortisation	2,524	1,442
Loss on disposals	0	3
Ring fenced expenditure		
Contingency planning teams	1,022	8,592
Trust special administration	0	7,364
Special measures reimbursements	2,127	2,119
Total other operating expenditure	**17,281**	**32,798**

Commentary on activity during the year is contained within the Annual Report.

5. Miscellaneous income

	year ended 31-03-16 £000's	year ended 31-03-15 £000's
Miscellaneous income	97	1
	97	**1**

Miscellaneous income received in 2015/16 includes contributions to joint projects and events from NHS England and the Department of Health.

6. Analysis of net expenditure by Programme and Administration budget

Programme spend comprises costs of Trust Special Administration, Special Measures improvement and buddying, and spend on the costing and coding assurance programme.

	31-03-16 £000's	31-03-15 £000's
Administration	60,290	60,234
Programme	6,120	12,018
	66,410	**72,252**

7. Non-current assets

a) Intangible assets

2015/16	Software licences £000's	Information technology £000's	IT assets under construction £000's	Total £000's
Cost or valuation				
As at 1 April 2015	1,004	1,149	3,362	5,515
Additions	772	0	2,214	2,986
Reclassification	0	4,440	(4,440)	0
Disposals	0	0	0	0
At 31 March 2016	**1,776**	**5,589**	**1,136**	**8,501**
Amortisation				
As at 1 April 2015	699	378	0	1,077
Charge for year	242	1,091	0	1,333
Disposals	0	0	0	0
At 31 March 2016	**941**	**1,469**	**0**	**2,410**
Net Book Value at 31 March 2015	305	771	3,362	4,438
Net Book Value at 31 March 2016	**835**	**4,120**	**1,136**	**6,091**

2014/15	Software licences £000's	Information technology £000's	IT assets under construction £000's	Total £000's
Cost or valuation				
As at 1 April 2014	806	580	1,148	2,534
Additions	198	0	2,783	2,981
Reclassification	0	569	(569)	0
Disposals	0	0	0	0
At 31 March 2015	**1,004**	**1,149**	**3,362**	**5,515**
Amortisation				
As at 1 April 2014	504	71	0	575
Charge for year	195	307	0	502
Reverse Disposals	0	0	0	0
At 31 March 2015	**699**	**378**	**0**	**1,077**
Net Book Value at 31 March 2014	302	509	1,148	1,959
Net Book Value at 31 March 2015	**305**	**771**	**3,362**	**4,438**

Spend on IT assets under construction in 2015/16 relates to development of a strategic information platform to address Monitor's increased demands for data analysis across a number of functions.

7. Non-current assets continued

b) Property, plant and equipment

2015/16	IT equipment	Furniture, fixtures and office equipment	Total
	£000's	£000's	£000's
Cost or valuation			
As at 1 April 2015	3,142	1,915	5,057
Additions	716	132	848
Disposals	(1)	0	(1)
At 31 March 2016	**3,857**	**2,047**	**5,904**
Depreciation			
As at 1 April 2015	1,686	816	2,502
Charge for year	887	304	1,191
Disposals	(1)	0	(1)
At 31 March 2016	**2,572**	**1,120**	**3,692**
Net Book Value at 31 March 2015	1,456	1,099	2,555
Net Book Value at 31 March 2016	**1,285**	**927**	**2,212**

2014/15	IT equipment	Furniture, fixtures and office equipment	Total
	£000's	£000's	£000's
Cost or valuation			
As at 1 April 2014	2,232	1,776	4,008
Additions	910	145	1,055
Disposals	0	(6)	(6)
At 31 March 2015	**3,142**	**1,915**	**5,057**
Depreciation			
As at 1 April 2014	1,034	531	1,565
Charge for year	652	288	940
Reverse Disposals	0	(3)	(3)
At 31 March 2015	**1,686**	**816**	**2,502**
Net Book Value at 31 March 2014	1,198	1,245	2,443
Net Book Value at 31 March 2015	**1,456**	**1,099**	**2,555**

All non-current assets are owned by Monitor.

8. Trade receivables and other current assets - amounts falling due within one year

	31-03-16 £000's	31-03-15 £000's
Trade and Other receivables	457	170
Prepayments and accrued income	271	645
	728	**815**

9. Cash and cash equivalents

	31-03-16 £000's	31-03-14 £000's
Balance at 1 April	7,913	18,638
Net change in cash and cash equivalent balances	78	(10,725)
Balance at 31 March	**7,991**	**7,913**
The following balances at 31 March were held at:		
Government Banking Service	7,976	7,900
Commercial banks and cash in hand	15	13
	7,991	**7,913**

10. Trade payables and other current liabilities

Amounts falling due within one year:	31-03-16 £000's	31-03-15 £000's
VAT	19	6
Other taxation and social security	1,242	944
Trade payables	4,417	5,753
Pensions payable	872	728
Accruals	3,616	5,591
Capital accruals	36	169
	10,202	**13,191**

11. Provisions for liabilities and charges

Monitor has no provisions in 2015/16 (2014/15: nil).

12. Commitments under leases

Total future minimum lease payments under operating leases are given in the table below for each of the following periods:

	2015/16 £000's	2014/15 £000's
Within 1 year	0	1,625
Within 2 to 5 years	0	0
After more than 5 years	0	0
	0	**1,625**

Monitor is in discussions with the Department of Health on future leases in the context of NHS Improvement's new operating model. Formal leases are expected to be signed later this year.

13. Capital commitments

There were no capital commitments at 31 March 2016 that require disclosure.

14. Related parties

Monitor is a non-departmental public body of the Department of Health, which is regarded as a related party. During the year, Monitor has had a number of material transactions with the Department.

In addition, Monitor has had a small number of transactions with other government departments and other central government bodies.

No Board or Executive team member or other related party has undertaken any material transactions with Monitor during the year.

15. Financial instruments

IFRS 7, Financial Instruments Disclosure, requires the disclosure of the role that financial instruments have had during the period in creating or changing the risk an entity faces in undertaking its activities. Financial instruments play a much more limited role in creating or changing risk for Monitor than would be typical of the listed companies to which IFRS 7 mainly applies.

As Monitor holds no financial instruments that are either complex or play a significant role in Monitor's financial risk profile, Monitor's exposure to credit, liquidity or market risk is limited.

16. Events after the reporting date

From 1 April 2016, the NHS TDA and Monitor will operate as part of NHS Improvement, with a new shared governance structure. The underlying legal entities of Monitor and NHS TDA will remain in place.

The annual report and accounts have been authorised for issue on the date the accounts were certified by the Comptroller and Auditor General.

This has no impact on Monitor’s accounts and no adjustments have been made as a result.

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ISBN 978-1-4741-2907-7

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety including the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

This publication can be made available in a number of other formats on request.

 Publication code: Corp 02/16